Institution of injunctive actions.
Institution of administrative proceedings of an enforcement nature.
Regulatory matter regarding financial institutions.
Settlement of injunctive actions.
Opinions.

At times, changes in the Commission priorities require alterations in the scheduling of meeting items. For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact: John Ramsay (202) 272–2100.

Dated: April 13, 1994.

Jonathan G. Katz,

Secretary.

[FR Doc. 94–9267 Filed 4–13–94; 8:45 am]
BILLING CODE 8010–01–M

federal register

Friday
April 15, 1994

Part II

Department of Health and Human Services

Social Security Administration

Disability Reengineering Project Proposal; Notice

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Security Administration

Process Reengineering Program; Disability Reengineering Project Proposal

AGENCY: Social Security Administration, HHS.

ACTION: Announcement of proposal and request for comments.

SUMMARY: The Disability Process Reengineering Team of the Social Security Administration (SSA) announces a proposal to redesign the disability claims process for Social Security Disability Insurance and Supplemental Security Income (SSI) Disability and Blindness benefits. This notice contains the Proposal (as well as background information) of the Disability Process Reengineering Team (composed of SSA and State Disability Determination Service (DDS) employees). The aim of the proposal is to achieve dramatic improvements in customer service to the public. Accordingly, we seek comments on the proposal to ensure that it meets the needs of the public. The comments will be weighed in the Agency's subsequent decisions on implementation.

DATES: To be sure that your comments are considered we must receive them no later than May 27, 1994.

ADDRESSES: Submit your comments as follows: (1) Mail them to the Social Security Administration, PO Box 17052, Baltimore, MD 21235, or (2) telefax them to (410) 966–9884, or (3) deliver them to 4–N–3 Operations Building, 6401 Security Boulevard, Baltimore, MD 21235, between 8 a.m. and 4:30 p.m. on regular business days. If you telefax your comments, please do not also mail a hard copy document.

FOR ADDITIONAL COPIES CONTACT: Social Security Administration, PO Box 17052, Baltimore, MD 21235, (410) 966–8255. The Proposal is available in alternative formats for visually impaired individuals. Please use this same telephone number to request the document in an alternative format

SUPPLEMENTARY INFORMATION:

Background—What is the Reengineering Program?

SSA began an Agency-wide program of Process Reengineering in the summer of 1993. The Process Reengineering Program is one way SSA is seeking to improve its overall service delivery process.

The Process Reengineering Program essentially asks the question, "If SSA had the opportunity today to design the processes, what would they look like?" In other words "how would we design a process if we were starting over?" The Program's objective is to fundamentally rethink and radically redesign SSA's work processes to achieve dramatic improvements in critical measures of performance. In this rethinking and redesign process, the ultimate aim is to achieve dramatically improved levels of service from the customer's perspective while enriching and improving the work lives of employees.

The Process Reengineering Program is the culmination of an investigation by SSA of the reengineering efforts conducted by companies, public organizations, academic institutions, and consulting firms with "hands on" experience. The very positive findings from that investigation, combined with our concerns about our ability to provide the very best service to the public, led to the conclusion that a process reengineering effort was absolutely critical to SSA's objective of providing "world class" service to the American public.

Based on analysis of what has worked best in other organizations, SSA developed a customized reengineering methodology. This methodology uses a reengineering team approach and combines a strong customer focus with classic management analysis techniques and computer modeling and simulation to intensely review a single business process. While the reengineering team is comprised of employees and experts who are very knowledgeable about the SSA process being redesigned, the methodology focuses heavily on obtaining the views of a broad segment of the public.

What Does the Disability Project Address?

Despite the outstanding efforts of SSA and State DDS employees throughout the country, we continue to have difficulty providing a level of service to claimants for disability benefits that approaches what would be considered "good" service. The steps in the current disability process have not changed in any important way since the beginning of the Disability Insurance program in the 1950s. Yet case loads, types of disabilities, and the demographic characteristics of individuals with disabilities who are potentially eligible for benefits have changed radically.

The State DDSs make the initial decisions about whether an applicant for Disability Insurance or SSI benefits is disabled. In 1989, SSA forwarded to the State DDSs 1.6 million claims for disability benefits in the Disability Insurance and SSI programs. Claims have increased significantly in every year since that time. In 1994, the number of disability claims we will forward to the State DDSs is expected to reach about 2.7 million. The number of requests for hearings on denied claims is expected to reach 522,000—an increase of about 60 percent in the last 3 years. The result is that many claimants have to wait much too long at each stage in the process. SSA and State DDS employees are working longer and harder, while becoming increasingly frustrated about their inability to provide the type of service the public deserves.

For these reasons, the first SSA reengineering project focuses on the process for claiming benefits—beginning with the initial claim and continuing through the payment of benefits or the final administrative appeal—under both the Disability Insurance program and the disability component of the SSI program.

The scope of the assignment to the disability reengineering project team did not include making any changes to the statutory definition of disability or the amount of benefits for which individuals are eligible. Other issues relating to the disability programs are being addressed by SSA in other ways, including the continuing disability review process and the referral of individuals for vocational rehabilitation services.

What the Proposal Contains

The proposal contained in this announcement is the product of the disability reengineering team. It begins by providing background on the current disability determination process. It discusses input received in person, by telephone and by mail, from almost 3,000 Social Security and State DDS employees, 750 members of the external community of individuals and organizations interested in SSA's disability programs, and from focus groups conducted with members of the public.

We next provide a conceptual proposal for a new disability claims process; it gives a view of how the new process will work from the applicant's perspective. Many readers will want to know how these concepts will actually work in detail. However, the development of that level of information will not be done until SSA is confident that the basic concepts presented here have the potential to achieve the level of service we seek to provide. We are committed to extensive future dialogue on the next level of detail once we make the final decision on these concepts.

The proposal contains many charts, some of which may be difficult to read in the **Federal Register** format. We considered deleting some of them but decided that the greater public interest was served by publishing the entire proposal as it was presented on March 31, 1994, to the Executive Steering Committee.

How Should Comments Be Presented to the Project Team?

The Project Team seeks public reaction to the concepts in the proposal. We are particularly interested in your response to the following questions concerning the proposal's goals:

- Does the proposal have the potential to provide a process that is easy for claimants and those who assist claimants to access and understand?
- Will it enable SSA and the State DDS to make the right decision the first time a case is adjudicated?
- Will it result in dramatically improved process times?
- Will it result in a more efficient use of SSA and State DDS personnel?
- Will it create jobs for employees in the process that are satisfying?

In considering these questions, you are encouraged to identify factors that would assure that the concepts presented will achieve these goals. To the extent that the proposal is not seen as achieving these goals, alternative suggestions about how to do so will be welcome.

What Happens Next?

The Project Team will receive all comments from the public and employees. The comments will be analyzed and used to revise and/or refine the proposal. The final proposal of the team will be presented to the Executive Steering Committee for the project for its review and recommendations. Members of this committee include SSA and HHS General Counsel executives, the presidents of the 8 union locals/councils that represent SSA employees, a State DDS Administrator, and the presidents of 6 associations of SSA and State DDS employees that work in the disability process.

The Commissioner of Social Security will seek the advice and recommendations of the Executive Steering Committee in making her decisions on how SSA will proceed.

Dated: March 29, 1994.

Rhoda M. G. Davis,

Director, Process Reengineering Program.

Introduction

A claimant for disability benefits from the Social Security Administration faces a lengthy, bewildering process. An initial decision from SSA will likely take more than three months. Anywhere from 16 to 26 employees will handle the claim before the initial decision is reached. If that decision is a denial, and the request for reconsideration is also denied, chances are the claimant will hire an attorney. It will likely be an additional eight months or more before a response on the hearing is received, and even longer before a check is issued or eligible dependents' benefits are paid. As many as 45 employees could handle the claim.

If the claim for benefits is approved after a hearing, the claimant will view the SSA disability application process as one which requires jumping through lengthy bureaucratic hoops. Dealing in person or on the telephone with SSA field office staff and, possibly, the State disability determination service (DDS) staff at the initial and reconsideration levels, the claimant must appear at a hearing and finally talk to a person in a position to make a decision on the claim. The claimant will rate SSA employees as courteous and knowledgeable, but the disability determination process as bureaucratic and unresponsive.

Congress agrees with this assessment; in May 1991, the House Ways and Means Committee cited SSA for an excellent job of delivering retirement benefits, but gave SSA a failing grade for the way it processes applications for disability benefits, with Chairman Dan Rostenkowski stating, "* * * those who are unfortunate enough to become disabled find their problems compounded by inefficiencies at SSA."

SSA employees reiterate this belief, as illustrated in the following statement by a claims representative, "I wish we could stop shuffling all this stuff back and forth. I don't really know what the DDS is looking for, so I try to do the best generic job I can on these forms."

The report of the National Performance Review reflected Administration concern by directing SSA to "Improve Social Security disability claims processing to better serve people with disabilities * * *".

SSA has reached a critical juncture; disability claims receipts at the initial claims and appeals levels have reached all time highs—Fiscal Year (FY) 1995 claims requiring a disability determination will increase 69 percent over FY 1990 levels; appeals workloads will increase 75 percent over FY 1990 receipt levels; employees in field offices, DDSs and hearing offices are overburdened despite recent significant increases in productivity. As an agency, SSA must vie for scarce administrative resources in an era of spending limitations and competing social spending priorities. The ability of SSA to cope with further workload increases is questionable; it is clear that only radical change can address the disability service delivery problems facing the Agency today.

SSA is meeting this challenge with an unprecedented effort to reengineer the entire disability process—from the point a potential claimant first contacts the Agency to file for disability benefits, through the disability allowance or final administrative appeal. Reengineering the disability process involves asking the question, "Given what we know about technology and resources available to us today, how can we best design a disability process for the 1990s and beyond?" This report will answer that question by proposing a radical redesign of disability program policies and procedures, to ensure dramatic improvements in the way the entire process works and is managed to serve the American public.

The report represents the collective efforts and recommendations of the 18-member Disability Reengineering Team, composed of Federal and State DDS employees, operating under the auspices of the Director of the SSA Process Reengineering Program, and the SSA Executive Steering Committee formed to provide advice to the Commissioner on the disability reengineering process change proposal development.

The Executive Steering Committee provided the following parameters for the disability reengineering proposal: "Every aspect of the process except the statutory definition of disability, individual benefit amounts, the use of an administrative law judge as the presiding officer for administrative hearings and vocational rehabilitation for beneficiaries is within the scope of this reengineering effort."

The recommendations in this report represent the Team proposal to SSA for reengineering the disability process; this is not a final SSA proposal. The Commissioner of SSA asks interested parties to comment on the proposal within the next 60 days. The Team looks forward to receiving comments from the community concerned with the delivery of disability benefits.

Current Process

The procedures in the current process have not changed in any significant way since the Social Security Disability Insurance (DI) program began in the 1950s, a time when caseloads, demographic characteristics of claimants, types of disabilities, and

available technology were radically different.

In the 1970s, Congress federalized State programs of cash assistance to the aged, blind and disabled into the Supplemental Security Income (SSI) program and added this to the responsibilities of SSA. SSA then adopted the DI disability determination procedures for SSI blind and disabled claims.

Overview

A claim must now pass through from 1 to 4 decisional paths within SSA to receive a favorable disability decision. The initial claim, reconsideration, administrative law judge (ALJ) hearing and Appeals Council review levels all involve multi-step uniform procedures for evidence collection, review, and decisionmaking.

The process starts at the initial level when an individual first applies for DI or SSI disability benefits on the basis of a disabling physical or mental condition. An individual calls the national toll-free telephone number and is referred to a local SSA field office or visits or calls one of 1,300 local field offices to apply for benefits. Field office personnel assist with application completion, obtain detailed medical and vocational history and screen nonmedical eligibility factors. Field office personnel forward the claim to 1 of 54 State disability determination services where medical evidence is developed and a final determination is made regarding the existence of a medically determinable impairment which meets the definition of disability.

After possible quality assurance review in the DDS or in the SSA regional Disability Quality Branch, the claim is returned to the field office. Thirty-nine percent of these claims were paid in FY 1993; denials are retained pending possible appeal. Allowed DI claims are sent to one of 7 processing centers (which include the Office of Disability and International Operations and the 6 Program Service Centers) for final processing and storage, as well as adjudication of claims for dependents. Allowed SSI claims remain in the field office for payment and retention.

An initial claim currently takes an average of 100 days to process from the time it is filed until a final decision is made according to SSA's computer-based processing time measurements. However, a better understanding of how long the process takes from the claimant's perspective comes from a 1993 study conducted by SSA's Office of Workforce Analysis, which showed that an average claimant waits up to 155 days from the initial contact with SSA until receiving an initial claim decision notice. Sixteen to 26 employees will handle the claim during this period.

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Figure 1

Initial Claim Process

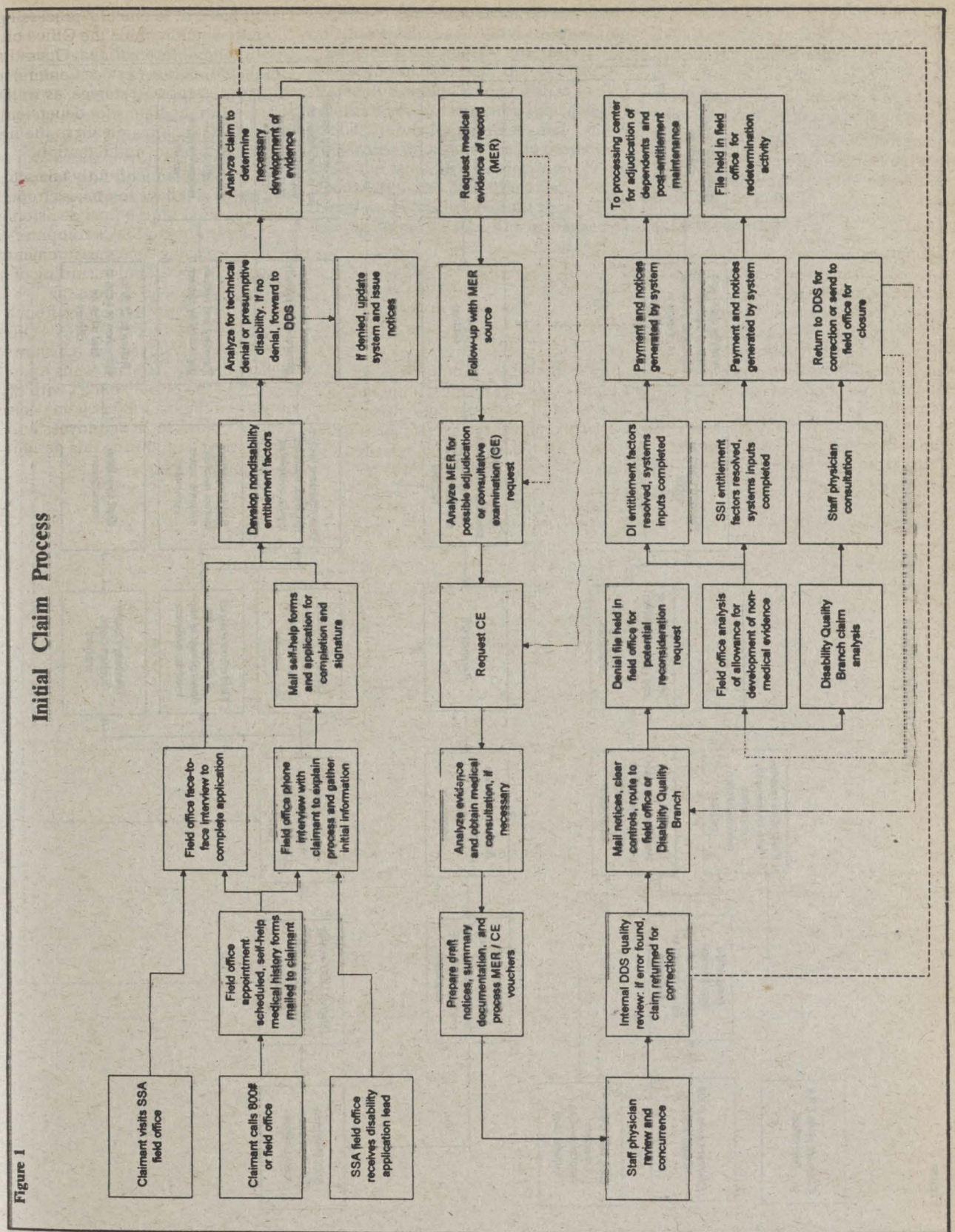
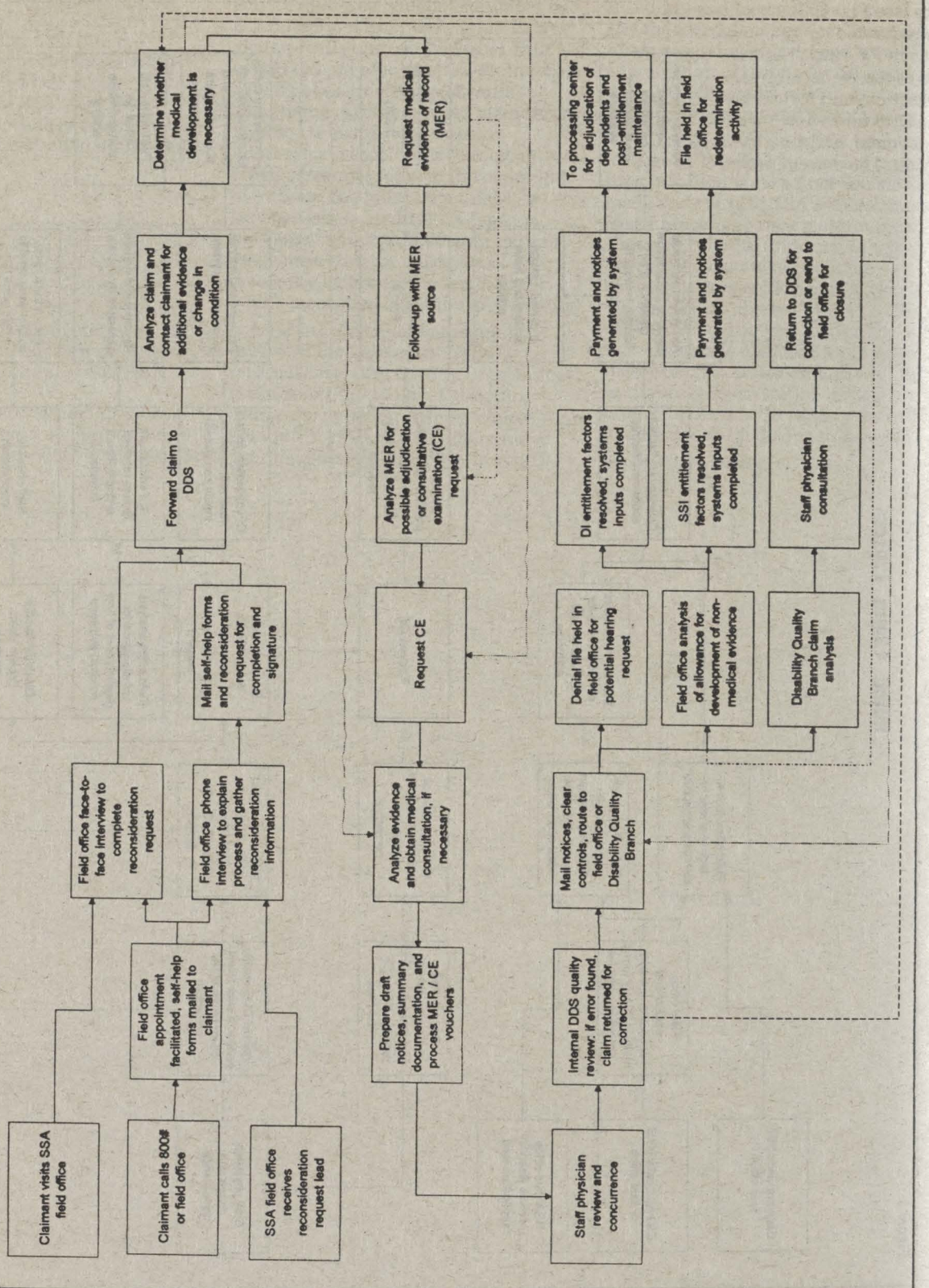


Figure 2

Reconsideration Level Process



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An appeal of the initial decision can be made within 60 days of the denial notice (see Fig. 2). Reconsiderations were requested on 48 percent of denied claims in FY 1993. The local field office receives the request, updates the information, and forwards the claim file to the DDS for review, possible medical development, and final medical decision. The determination is made by a different adjudicative team than the one that made the initial determination.

After possible quality assurance review in the DDS or in the regional Disability Quality Branch, about 14 percent of these claims are returned to the field office for payment, and forwarding to the processing centers, while the remaining denials are forwarded to the field office for retention, pending a request for a hearing before an ALJ. The average reconsideration itself takes about 50 days according to SSA's computer-based processing time reports—however, according to the Office of Workforce Analysis study, a claimant has now been involved with the SSA process for roughly 8 months from the point of initially contacting the Agency, and up to 36 different employees could have handled the claim.

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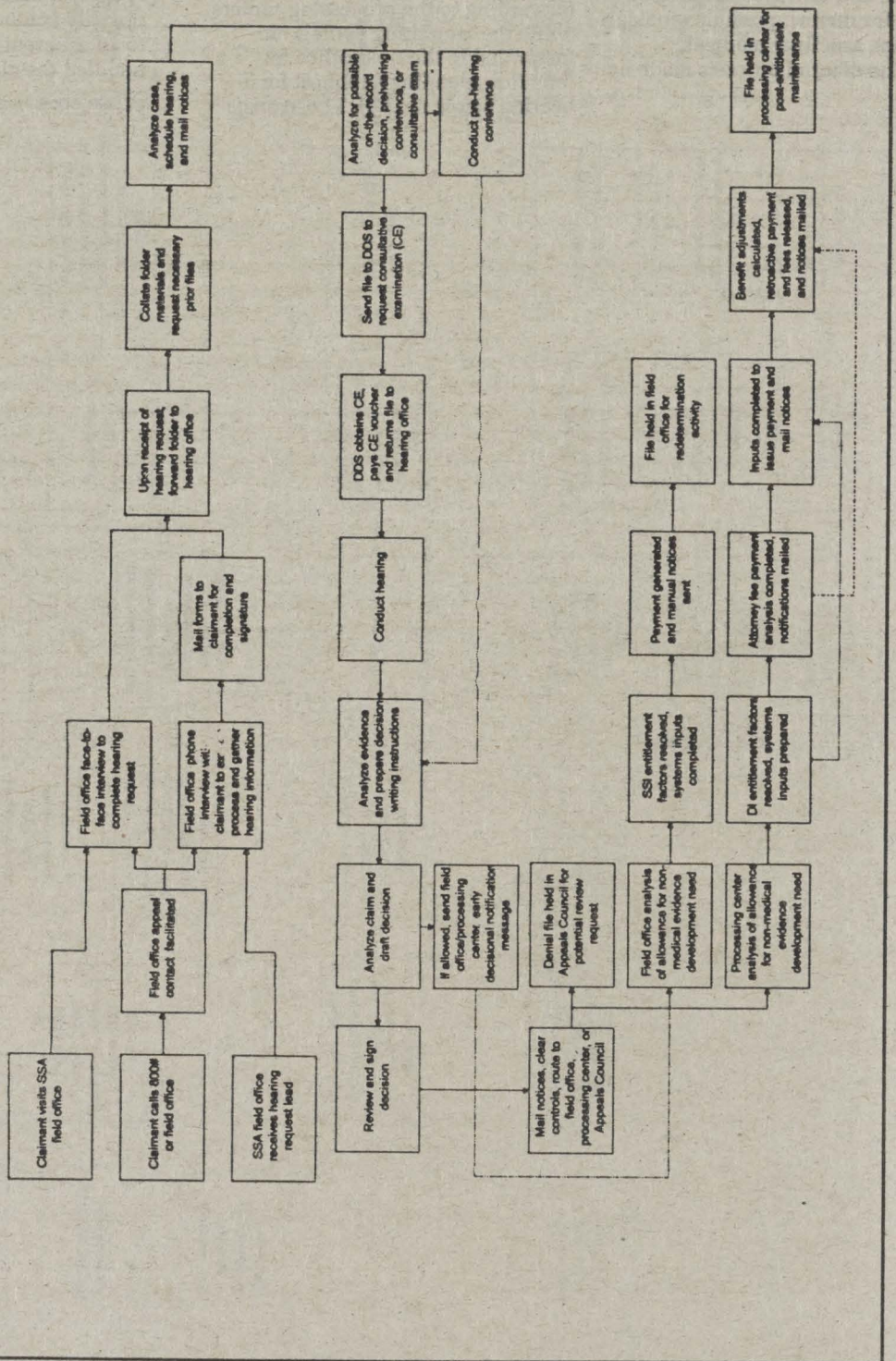
Figure 3

Hearing Level Process



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Within 60 days of receiving an unfavorable reconsideration decision, a claimant can request a hearing before an ALJ (Fig. 3). In FY 1993, about 75 percent of all reconsideration denials were appealed to ALJs. At this point, a claimant has usually retained an attorney or other representative to assist in pursuing the claim for benefits. About 75 percent of all claimants retain a representative at the hearing. The local field office receives the request for hearing and forwards it with the claim file to one of 132 local SSA hearings offices. Hearing office personnel review the file for possible additional development, conduct a hearing, and render a final decision.

Allowed DI claims are sent to a processing center for final action and storage, as well as adjudication of claims for dependents. Allowed SSI claims are returned to the local field office for income and resource development, and payment. Denied claims are forwarded to the Appeals Council for retention in case a request for review is filed. The hearing process itself takes about 265 days according to computer-based reports. However, according to the Office of Workforce Analysis study, a claimant has been dealing with SSA for over a year and a half at this point in the process.

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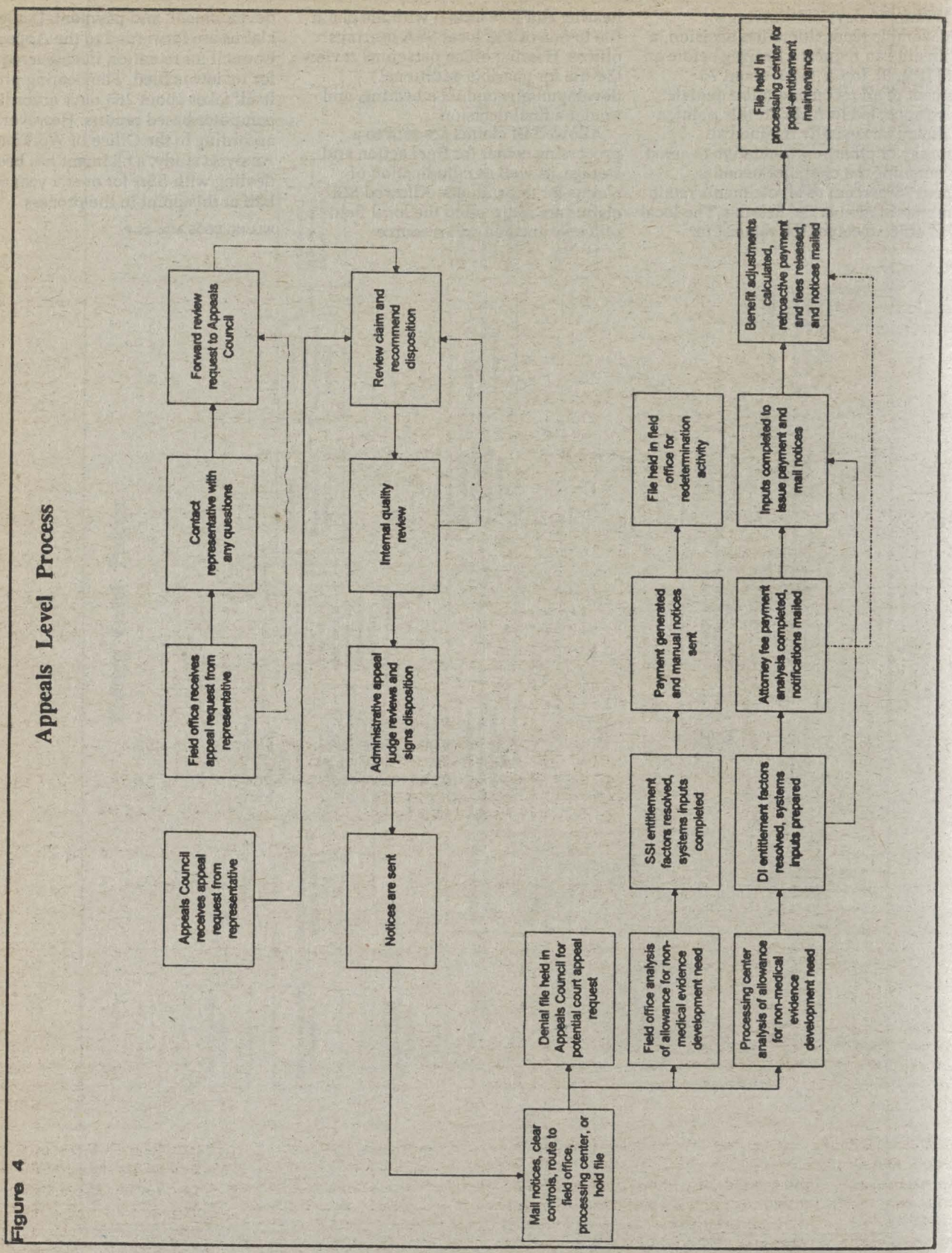

Figure 4

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If still dissatisfied with an unfavorable decision, a claimant or representative has 60 days to request a review of the ALJ decision by the Appeals Council (Fig. 4). About 23 percent of hearing decisions are unfavorable and forwarded to the Appeals Council pending possible appeal. The Appeals Council considers about 18 percent of all ALJ dispositions, including cases it reviews on its own motion.

Requests for Appeals Council review are typically received directly from the claimant's representative. The Appeals Council may either deny review, issue a decision, or remand the claim to an ALJ. The Appeals Council remands claims to the ALJ level about 27 percent of the time for subsequent development and decision. Denied claims, representing about 70 percent of the Appeals Council dispositions, are held in the Appeals Council for possible appeal to Federal District court.

Allowed DI claims are sent to a processing center for final action and storage, as well as adjudication of claims for dependents. Allowed SSI claims are returned to the local field office for income and resource development, and payment. According to processing time reports, this part of the process takes on average about 100 days; however, according to the Office of Workforce Analysis study, a claimant has spent almost 2 years dealing with SSA since initially contacting the Agency.

Trends

The current disability process served SSA and the public well for a number of years. However, over the last several years, as workloads have increased dramatically, the current process has been placed under increasing stress. The upward trend in the number of claims for benefits SSA has received is reflected as follows:

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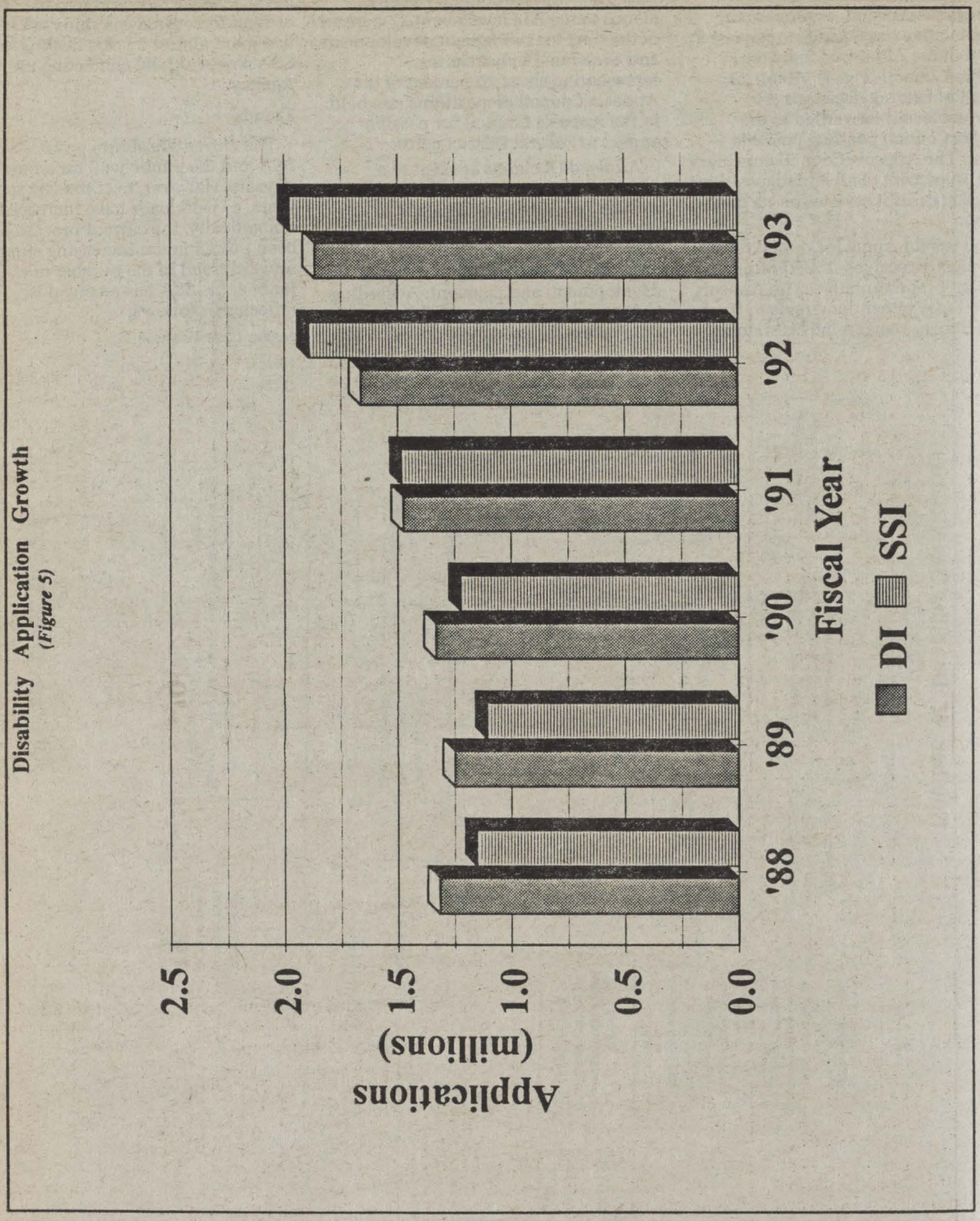

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The growth in claims and benefits awarded is reflected in increases in the number of beneficiaries SSA pays and the growth in Federal program outlays over recent years.

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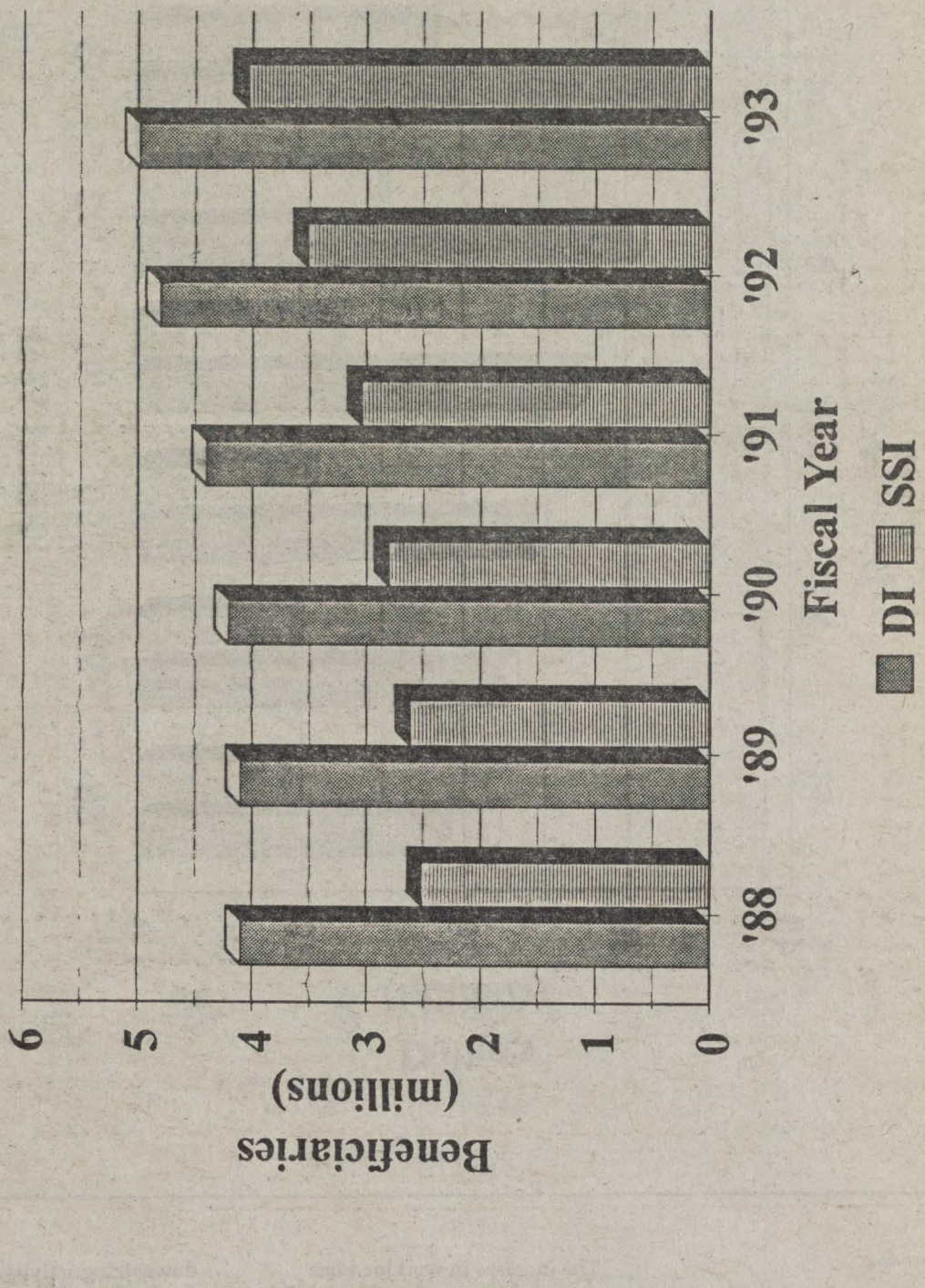
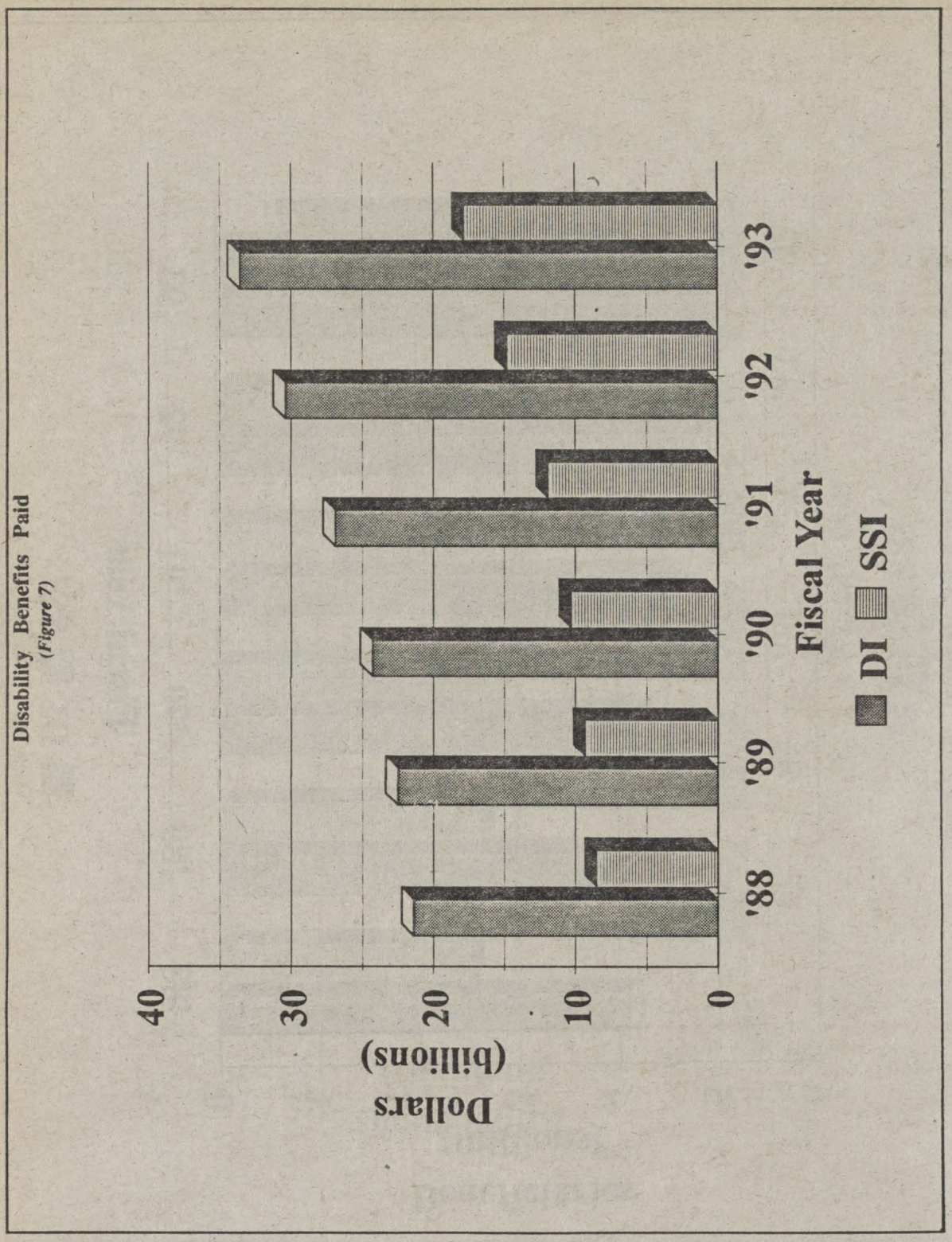
Number of Disability Beneficiaries
(Figure 6)





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The increase in workload has occurred concurrently with significant downsizing activity in SSA and staffing fluctuations in the State DDSs.

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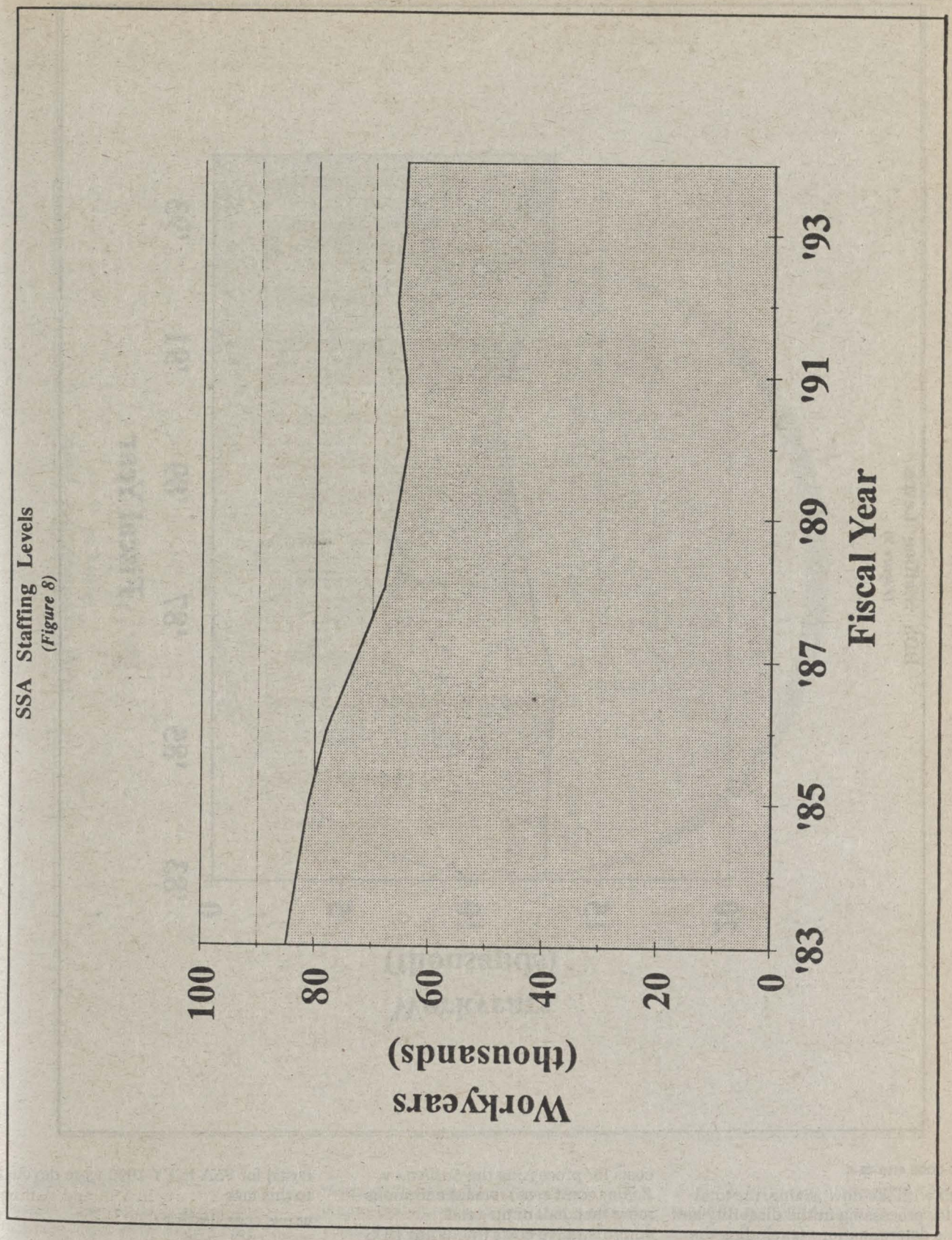
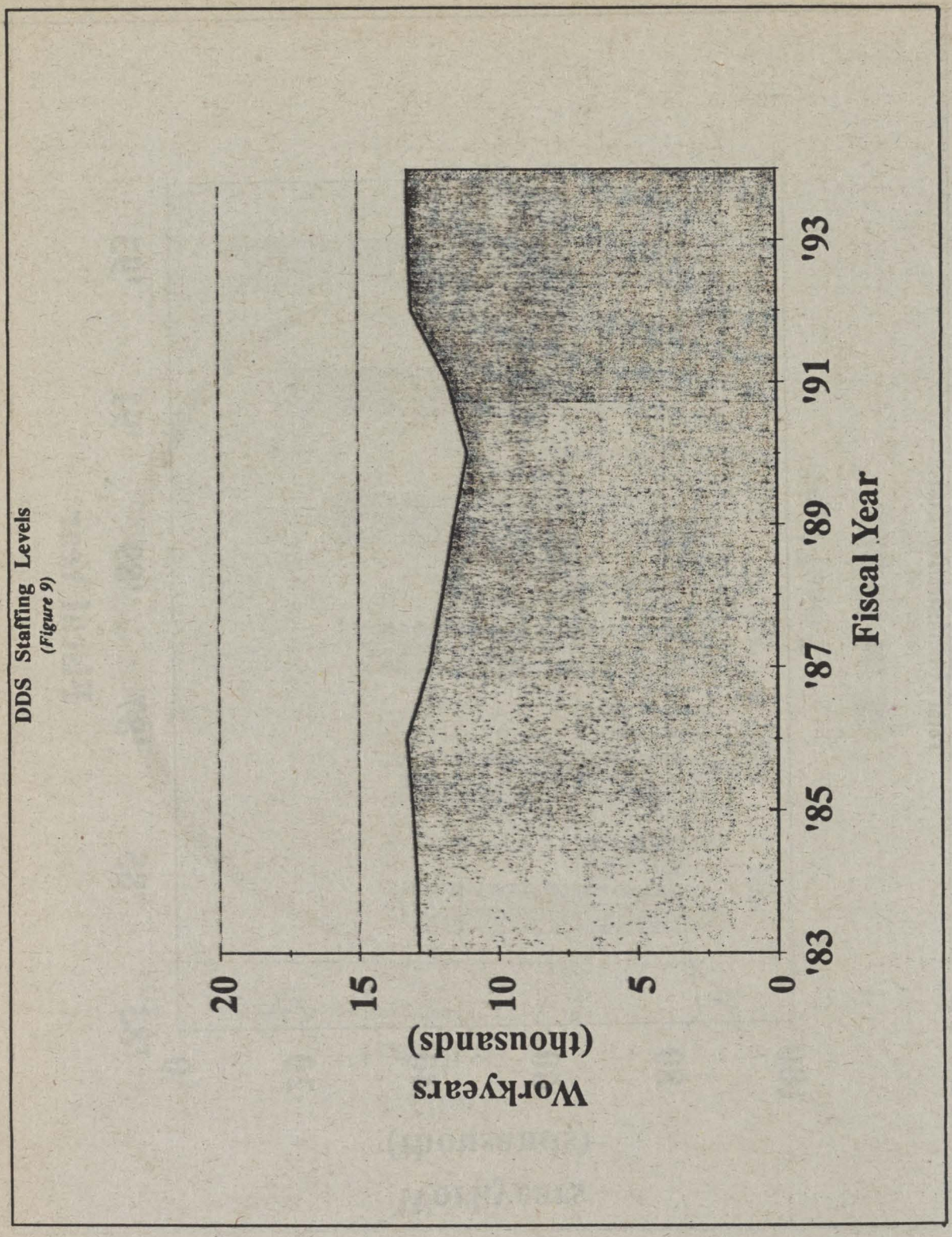

SSA Staffing Levels
(Figure 8)
Workyears
(thousands)
100
80
60
40
20
0
'83
'85
'87
'89
'91
'93
Fiscal Year



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Even with the downsizing, the total costs for processing initial disability and appeals determinations (excluding the costs for processing the *Sullivan* v. *Zebley* court case) remain enormous—more than half of the total administrative costs (including DDS costs) for SSA in FY 1993 were devoted to this task.

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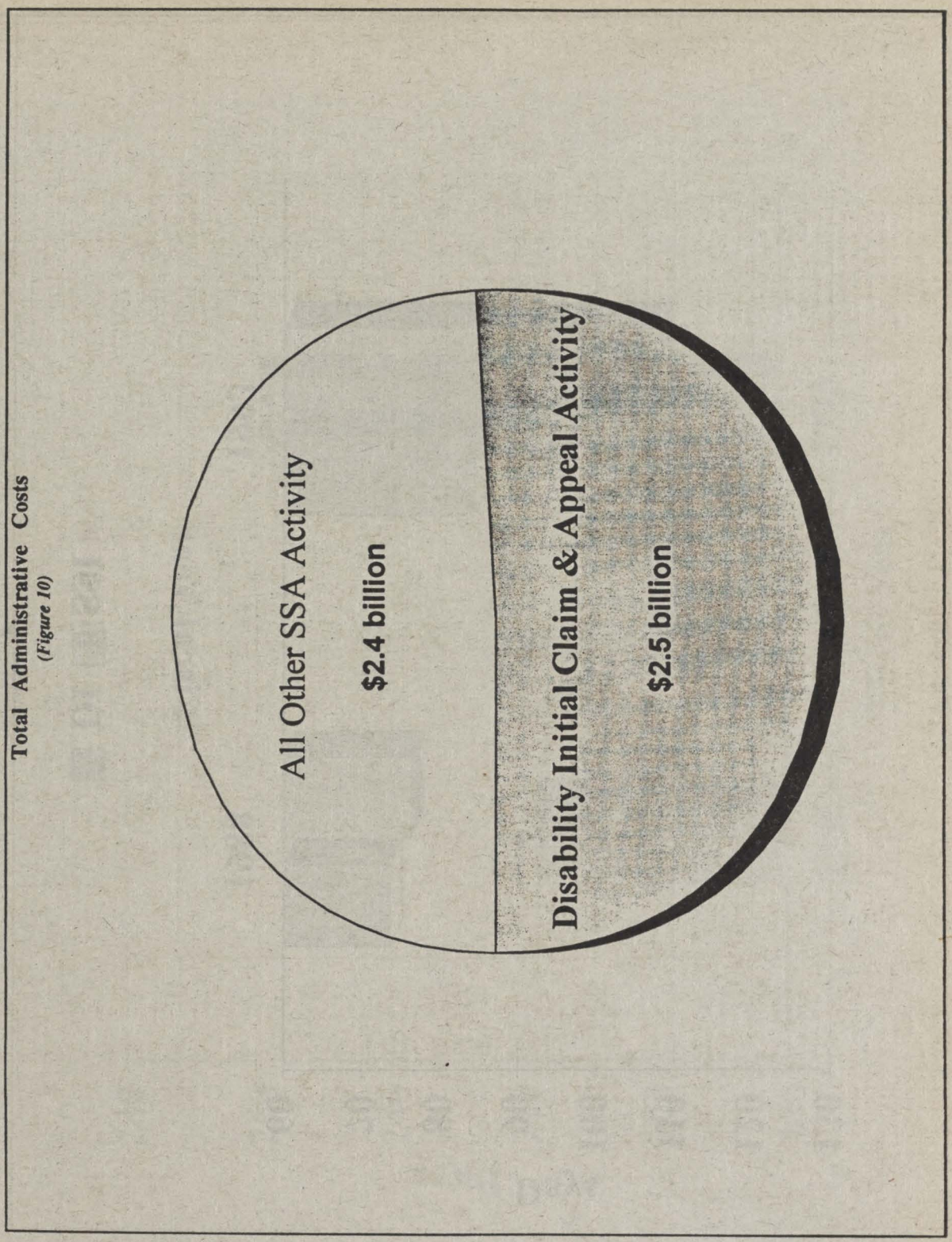

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Despite these funds, and despite directing a larger percentage of the SSA resources toward disability initial claims and appeals processing in recent years, average processing times for initial claims, as well as appeals, have escalated dramatically since 1988.

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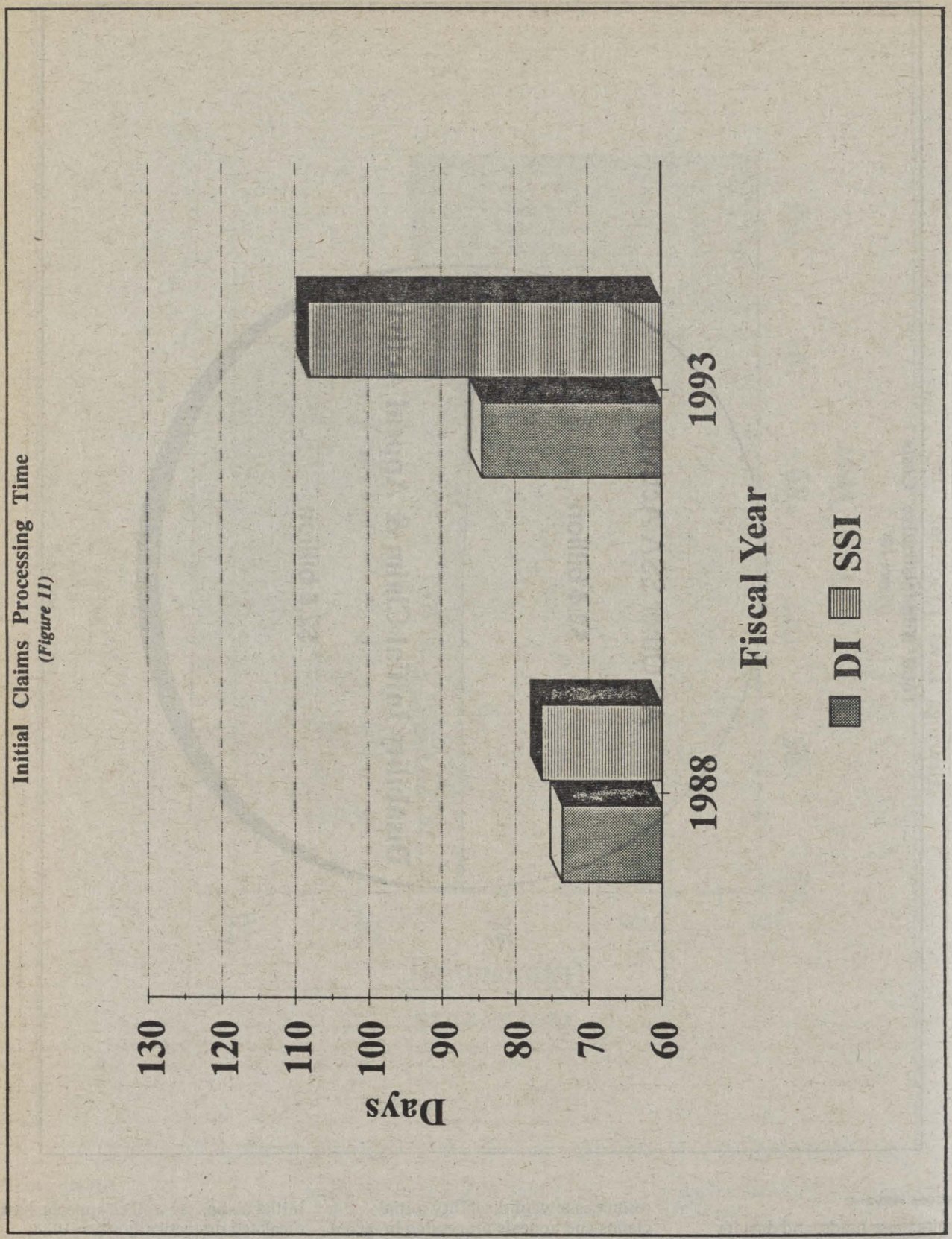
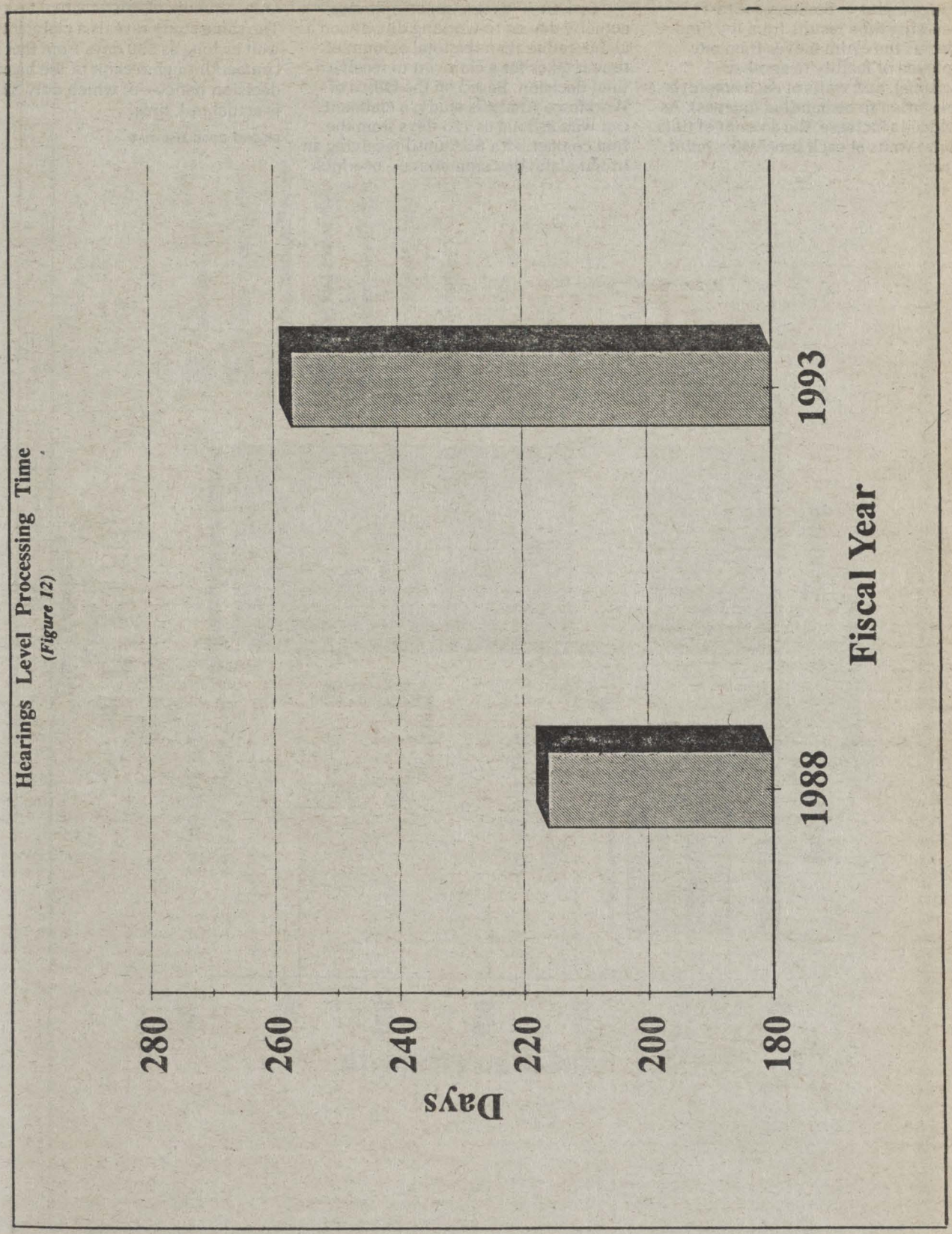

Initial Claims Processing Time
(Figure 11)
Days
130
120
110
100
90
80
70
60
1988
1993
Fiscal Year
DI
SSI



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At least part of the increase in processing time results from the time added as the claim moves from one employee or facility to another (handoffs), and waits at each employee's workstation to be handled (queues). As workloads increase, the amount of time a claim waits at each processing point grows.

"Task time" is the time employees actually devote to working directly on a claim, rather than the total amount of time it takes for a claimant to receive a final decision. Based on the Office of Workforce Analysis study, a claimant can wait as long as 155 days from the first contact with SSA until receiving an initial claim decision notice—of which only 13 hours of this is actual task time. The same study reveals a claimant can wait as long as 550 days from that initial contact through receipt of the hearing decision notice—of which only 32 hours is actual task time.

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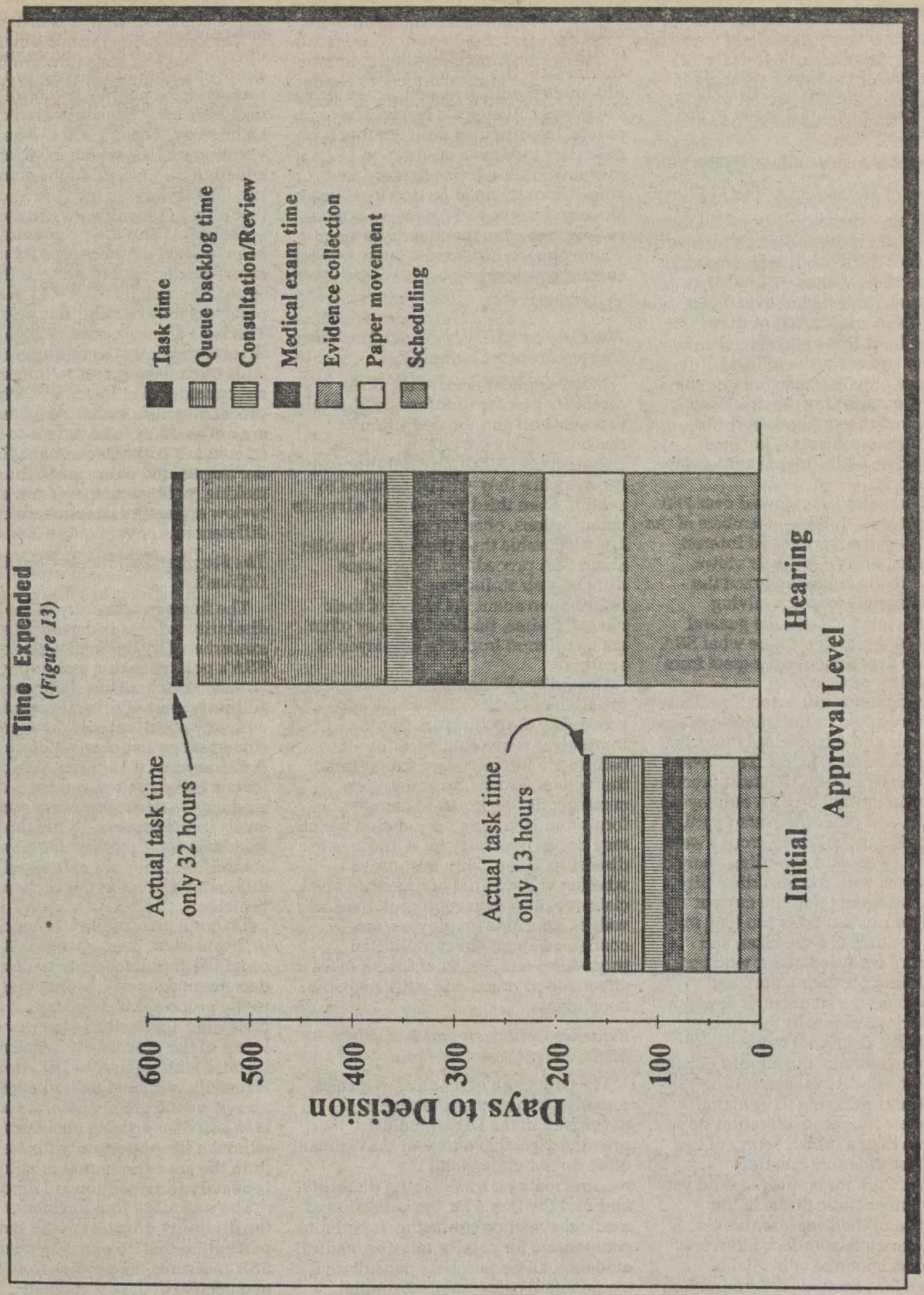

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The Team's research revealed that the problems of queues, handoffs, and task time are compounded by problems with the way SSA takes claims, collects evidence, and determines disability. These problems are discussed in the following section.

Research Summary and Analysis

Overview of Methodology and Findings

The Team's methodology called for extensive site visits and interviews with members of the disability community. Team members visited 421 locations in 33 States and conducted over 3,600 interviews. Almost 2,900 of these involved front-line employees, managers and executives. The interviews provided insights into the problems confronting the disability program and recommendations for solving these problems. The Team conducted an additional 111 interviews by telephone.

The Team also interviewed over 750 parties external to SSA—members of the medical, legal, advocate and interest group community—for their views. Finally, the Team has analyzed the results of focus groups involving disability claimants and the general public in order to determine what SSA customers experience and expect from the disability process.

The information collected from these activities resulted in the framework for the analysis and recommendations that follow. At a minimum, the Team was determined to address the most pressing problems identified by SSA employees, claimants, and other interested parties. Not surprisingly, all three groups were in general agreement regarding many of the problems with the SSA disability process. All agreed that the current fragmented process takes too long to provide applicants a decision, and leaves them confused about who has responsibility for their claim, and puzzled about the status of their claim during various points in the process. Additionally, nearly all believe that many claimants can and should assume more responsibility for submitting evidence and pursuing their claim.

Most view the reconsideration step as little more than a rubber stamp of the initial determination, creating additional work for employees and yet another bureaucratic obstacle for claimants and their representatives. Some believe a face-to-face interview with the decisionmaker is vital to reaching a fair, accurate determination; others believe just as strongly that the decision should be reached on the basis of a paper review, and that a face-to-face interview can lead to subjective decisions that are not based on objective criteria.

Higher allowance rates at the ALJ level lead to the perception that different adjudicative standards apply at the initial and appeals levels. The public, in particular, believes that it is necessary to hire an attorney to maneuver through this process, and voices resentment at having to do so. Quality reviews and Appeals Council reviews are often mentioned as areas where opportunities exist for improving current processes.

The Case for Change

The Public and Third Parties Find the Current Process Confusing

Many applicants enter the SSA disability process uninformed about the process itself and the definition of disability. They are unaware of the criteria for establishing disability and the evidence they will be required to submit. Even third parties and advocate organizations, often more knowledgeable than the general public about SSA procedures, experience difficulty obtaining meaningful information about the status of their clients' claims, finding that they often are transferred from one employee to another.

Disability claimants face a "one size fits all" approach to the intake and processing of their claim, finding themselves answering questions they believe are intrusive and irrelevant to their claim. Front-line employees currently devote hours to completing forms and obtaining information which may not be necessary for a finding of disability. If the claim is approved, whether at the initial or appellate level, claimants and their representatives, as well as front-line employees, are concerned about the complicated procedures and length of time it takes to effectuate payment and entitle eligible dependents.

Evidence Collection and Decision Methodology Pose Problems

The collection of medical evidence presents problems as the case is developed in the DDS. Medical providers who have treated the claimant often do not understand the requirements for establishing disability, and find the forms for the collection of medical evidence confusing. In order to compensate for poor or missing medical evidence, DDSs purchase consultative examinations, devoting substantial resources to scheduling, purchasing, and processing these examinations.

Once the medical evidence has been collected, the methodology used to reach a decision on the case is complex and controversial. Criteria originally developed to identify and evaluate cases simply and rapidly have grown increasingly complex as a result of court decisions and changes in medical technology. Today's 330 different vocational rules, which have been added to SSA's regulations since 1980, can lead to varying interpretations resulting in inconsistent decisions.

Claimants and their representatives have learned their chances for a favorable decision improve if they appeal their claim to an ALJ. A variety of factors may be contributing to this. The facts of many cases change over time as a claimant's condition changes. ALJs often have access to information not considered at lower levels in the process because earlier decisionmakers are not as likely to have face-to-face interaction with the claimant. Finally, the fragmented nature of SSA's policy making, policy issuance, training and review apparatus all reinforce the differences.

The Fragmented Process Contributes to Difficulties

The fragmented nature of the disability process is driven by and exacerbated by the fragmentation in SSA's policy making and policy issuance mechanisms. Policy making authority rests in several organizations with few effective tools for ensuring consistent guidance to all disability decisionmakers. Different vehicles exist for conveying policy and procedural guidance to decisionmakers at different levels in the process. While the standards for disability decisionmaking are uniform, they are expressed in different wording in the various policy vehicles.

Training on disability is not delivered in a consistent manner, nor is it provided simultaneously to disability decisionmakers across or among levels in the process. Mechanisms for reviewing application of policy among levels of the process are fragmented and inconsistent. Review of DDS decisions is heavily weighted toward allowances; no systematic quality assurance program is in place for hearing decisions although the opportunity for feedback from the appeals council or court cases is heavily weighted toward denials.

The organizational fragmentation of the disability process creates the perception that no one is in charge of it. SSA measures the process from the perspective of the component organizations involved, rather than the perspective of the claimant. Multiple organizations (field offices, DDSs, hearings offices, Appeals Council

operations, and processing centers) have jurisdiction over the claim at various points in time, with each line of authority managing toward its own goals without responsibility to the overall outcome of the process. Additionally, the impact of one component's work product on other components is not measured, further contributing to the fragmentation of the process. Each component's narrow responsibilities reinforce a lack of understanding among component employees of the roles and responsibilities of other employees in different components.

Customer Research and Demographics

Customer Research

The National Performance Review report, released in the fall of 1993, calls upon agencies to establish customer service standards *equal to the best in the business* to guide their operations. Federal agencies are encouraged to identify "the customers who are, or should be served by the agency," and survey these customers "to determine the kind and quality of services they want and their level of satisfaction with existing services."

SSA customers include the individuals who file for social security or supplemental security income disability benefits, or who are potential filers for these benefits. They were surveyed through a series of 12 focus groups conducted throughout the country last fall. Participants represented a demographically diverse cross-section of current claimants, including those who had been initially denied, and who filed for a reconsideration or hearing; new beneficiaries; and the general public. Two focus groups were conducted with non-English speaking participants.

Focus group participants were quick to offer their frank opinions; the general view was that they:

—Wait too long for a decision—this is the most common complaint; the claim process is a struggle characterized by stress, fear, and the anger associated with running out of funds;

—Do not understand the program or process—what happens to the claim after initial contact with SSA is unclear, they view SSA multiple requests for medical information with skepticism, do not understand their decision and believe it was reached arbitrarily;

—Want more information and personal contact—while they would prefer to deal with one person for all claim business, their major preference is to receive accurate, consistent information from all SSA sources and to be provided substantive status reports on their claim;

—View the initial and reconsideration denials as bureaucratic precursors to final approval at the ALJ level—they believe the process is designed "to make you go away";

—Resent the need for attorney assistance to obtain benefits—the process should not be so complicated that an attorney is needed; and

—Want more active involvement in pursuit of their claim—they want to make their case directly to the decisionmaker, and would personally obtain needed additional evidence to speed the decision on their claim.

Demographics

Changes in demographics of the general population and in SSA's claimant population present challenges as well as opportunities for SSA as it focuses on claimant needs and reengineers its disability determination process.

American society has changed dramatically since the DI program began in the 1950s. This is reflected in an increased demand for SSA's services, changes in the characteristics of claimants seeking benefits, and complexities in claim related workloads and processes.

The demographic character of the SSA disability claimant population has changed as well. The enactment of the SSI program in the 1970's added individuals who have sketchy work histories, increased the number of individuals filing based on disabilities such as mental impairments, and provided for eligibility of disabled children. Additionally, the requirements of the SSI program added complex and time consuming development of non-disability eligibility factors such as income, resources and living arrangements. The 1990 U.S. Supreme Court decision, *Sullivan* v. *Zebley*, resulted in increased claims for children; children comprised 21 percent of all SSI claims in 1992, up from 11 percent in 1988. Claims for homeless individuals and others with special needs have increased in recent years. These claimants require significant intervention and assistance to navigate the disability claims process.

A trend in the general population which is reflected in SSA's disability claimant population is the increased number of people in the United States for whom English is not the native language. Recent national Census data indicate that 1 in 7 people speak a language other than English in the home; this is an increase of almost 38 percent in the last 10 years. SSA will need to accommodate the special communication needs of these claimants in its ongoing claimant contacts and in public information vehicles.

Forty percent of claimants filing for disability benefits and polled in a recent SSA survey had filed for or received benefits from Aid to Families with Dependent Children, welfare or social services within the past year. Approximately three-fourths of them were awarded this assistance and three-fourths of those awardees were still receiving benefits when they applied for disability benefits. SSA has the opportunity to develop productive relationships with these entities to improve the processing of disability claims for mutual customers.

Technological advances such as personal computers, facsimile machines, electronic mail, and videoconferencing are increasingly available to our claimants, their representatives, medical providers and other third parties involved in the disability process. SSA can take advantage of these capabilities to offer expanded service options and to modernize evidence collection.

New Process

Overview

A claimant for disability benefits under the proposed process will be provided a full explanation of SSA's programs and processes at the initial contact with SSA. The claimant and third parties will be able to assist in the development of the claim, deal with a single contact point in the Agency, and request a personal interview with the decisionmaker at each level of the process. Additionally, if the claimant requests a hearing, the issues and evidence to be addressed at the hearing will be focused, the responsibilities of representatives clarified and, if the claim is approved, the effectuation of payment to the claimant, eligible dependents and the representative streamlined.

The new process will result in a correct decision at the initial level by simplifying the decision methodology, providing consistent direction and training to all decisionmakers, enhancing the collection and development of medical evidence, and employing a single quality review process across all levels.

A single claim manager will handle most aspects of the initial level claim, thus eliminating many steps caused by numerous employees handling discrete

parts of the claim (handoffs) and the time lost as the claim waits at each employee's workstation to be handled (queues). This will reduce the time needed to rework files and redevelop information from the same medical sources. Levels of appeal will be combined and improved, reducing the need to redevelop nonmedical eligibility factors after a favorable decision because less time will have elapsed since initial filing.

The proposed process will enable the current work force to handle an increased number of claims, freeing the most highly skilled staff (physicians and ALJs) to work on those cases and tasks that make the best use of their talents, and targeting expenditures for medical evidence to those areas most useful in determining disability.

Employees will perform a wider range of functions, using their skills to their full potential, enabling them to meet the needs of claimants and minimize unnecessary rework. The proposed process will facilitate employees' ability to do the total job by providing technology and the support to use that technology.

The New Process—A Brief Description

Under the proposed process, the number of appeal steps will be reduced and opportunities for personal interaction with decisionmakers will be increased. At the initial claim level, the claimant will be offered a range of options for filing a claim, pursuing evidence collection, and conferring with a decisionmaker, using various modes of technology to interact with SSA. At the hearing level, the claimant will have an additional opportunity to participate in a personal conference and meet with a decisionmaker.

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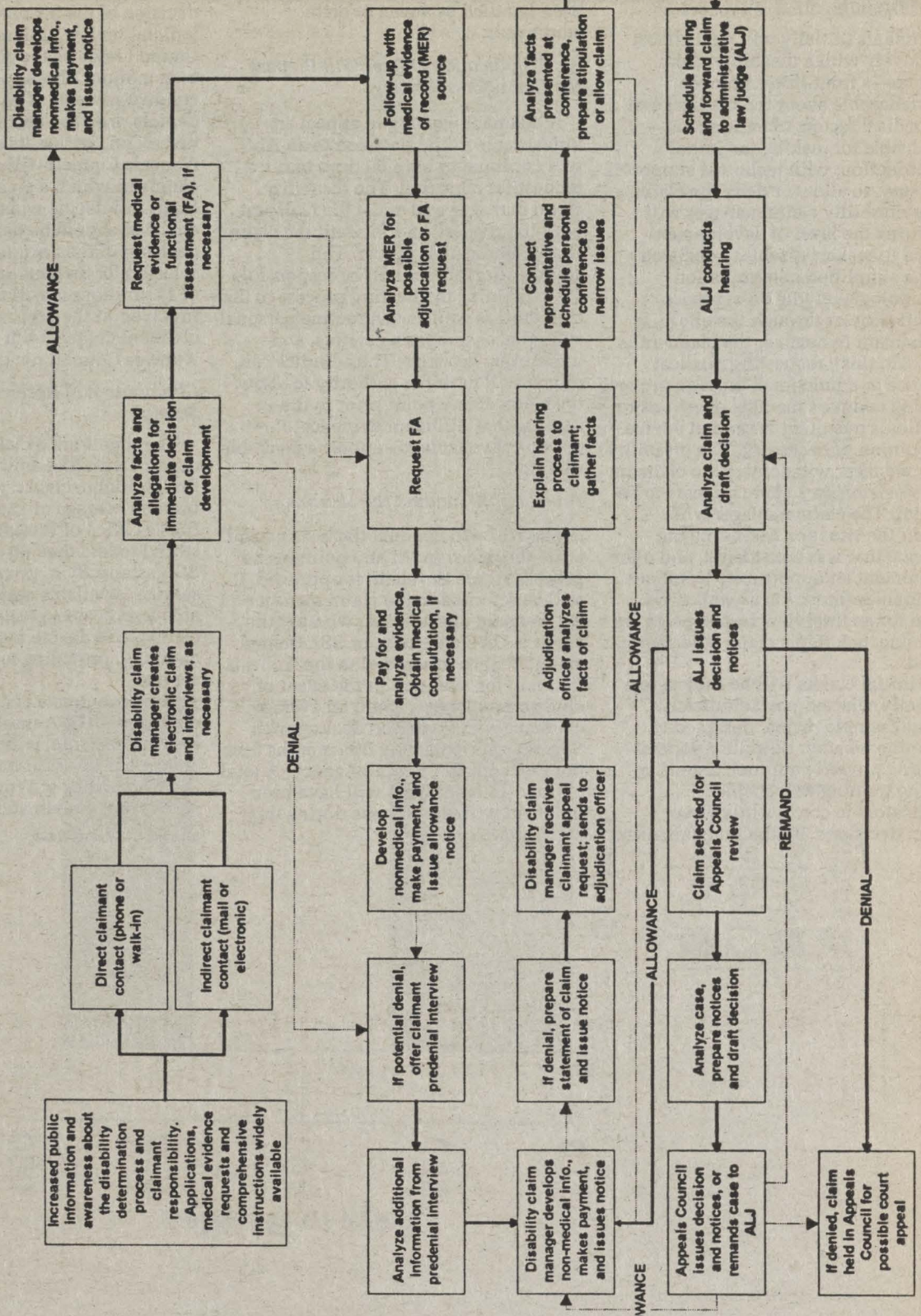
Figure 14

The New Disability Claim Process



A Disability Claim Manager Will Handle Initial Disability Claims Processing

Claimants initially will deal almost exclusively with a disability claim manager—a front-line employee knowledgeable about the medical and nonmedical factors of entitlement—responsible for making the initial determination, with technical support if necessary, to allow or deny the claim.

The disability claim manager will determine the level of development needed to make a disability decision using a simplified determination methodology; relying on evidence submitted by or through the efforts of the claimant (whenever the claimant is able to do this); requesting medical evidence or a functional assessment; or referring complex medical questions to a medical consultant for expert advice and opinion, if necessary. The disability claim manager will contact the claimant if the decision on a claim appears to be a denial. The claim manager will explain the situation including the evidence that was considered, and offer the claimant an opportunity to submit additional information as well as an option for an interview in-person or via telephone, before the claim is formally denied.

All initial claims will be subject to a randomly selected postadjudicative national sample review designed to determine whether disability policies are being properly applied. Extensive ongoing training will enable adjudicators to consistently issue correct decisions. By the time the initial decision is issued, the claim will have been handled by seven or eight employees.

An Adjudication Officer Will Prepare the Claim for a Hearing

A claimant wishing to appeal an unfavorable initial decision to an ALJ will continue to have 60 days to file a request for a hearing. The disability claim manager will assist the claimant with the request, and forward the claim to an adjudication officer. The adjudication officer will be responsible for explaining the hearing process to the claimant, as well as conducting personal conferences, preparing claims, and scheduling hearings. The adjudication officer will have the authority to allow the claim at any point prior to the hearing that sufficient evidence becomes available to support a favorable decision.

An ALJ Will Conduct the Hearing

The ALJ will conduct the hearing and issue the decision. At any point in the process where the claim is approved, it will be returned to the claim manager for payment effectuation, whether the claim is DI, concurrent, or SSI. Denied claims will be forwarded to the Appeals Council, for retention in the event of civil action. At this point, an average claimant will have been dealing with SSA for approximately five months from the first contact with the Agency. A total of up to 14 employees will have been involved with the process during this entire period.

An ALJ decision will be the final decision of the Secretary, subject to judicial review, unless the Appeals Council reviews the ALJ decision on its own motion. The Appeals Council will conduct reviews of ALJ allowances and denials prior to effectuation, at its discretion, and on its own motion. The Appeals Council will also review all claims in which a civil action has been filed, and decide whether the ALJ decision should be defended as the final decision of the Secretary. If a claim is selected for own motion review, a total of 17 employees will have been involved in the process from first claimant contact with SSA through Appeals Council review.

Claimants Will Receive World-Class Service

The time from a claimant's first contact with SSA until issuance of a final initial decision, will be reduced from an average of 155 days (as cited in SSA's Office of Workforce Analysis study) to less than 40 days, enhancing SSA's capacity to provide world-class service. Available employees will be able to process a greater number of claims, and devote more time to each claimant, providing more personalized service.

The time from a claimant's first contact with SSA until issuance of a hearing decision, will be reduced from an average of a year and a half (as cited in SSA's Office of Workforce Analysis study) to approximately 5 months.

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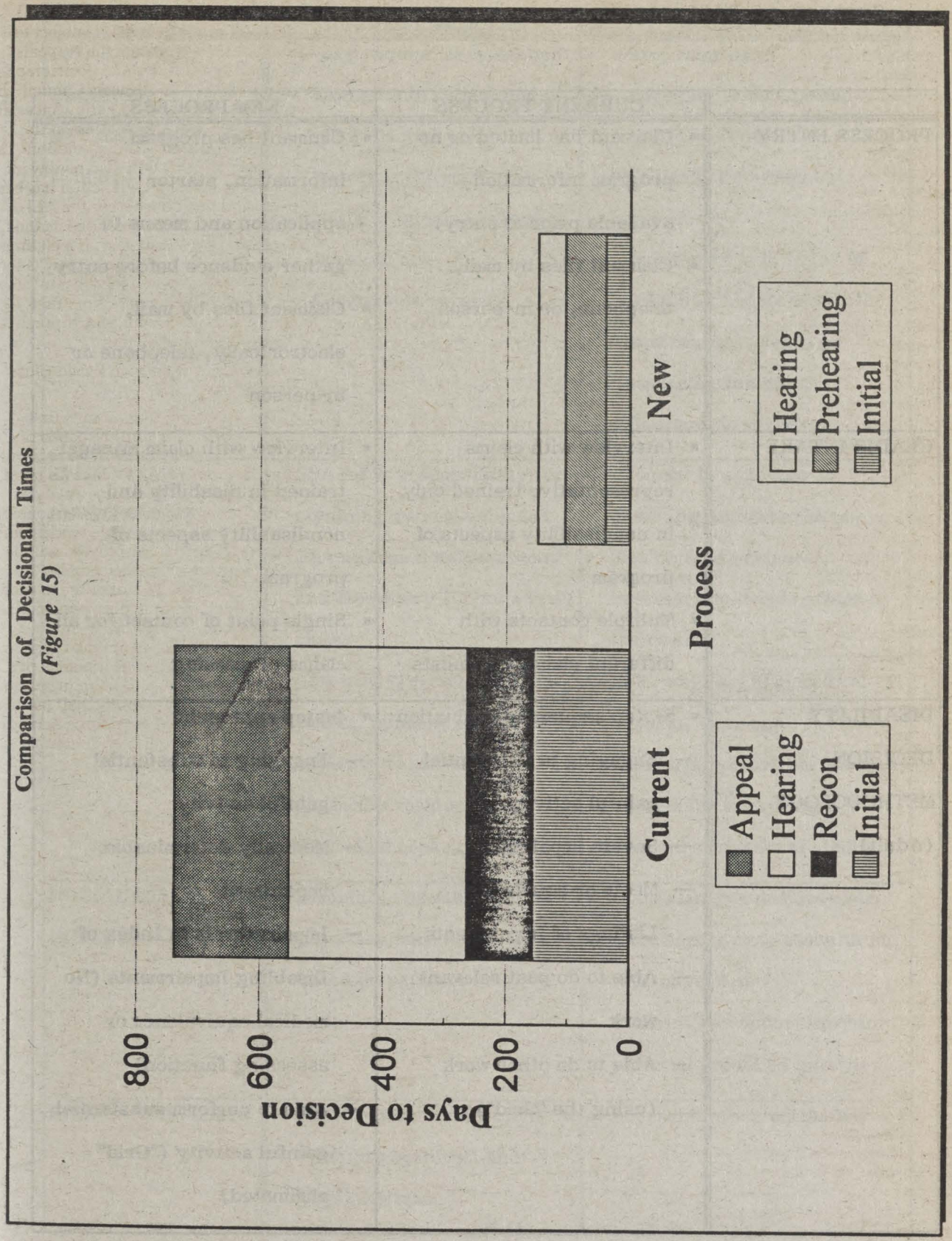
Comparison of Decisional Times
(Figure 15)
Days to Decision
800
600
400
200
0
Current
New
Process
Appeal
Hearing
Recon
Initial
Hearing
Prehearing
Initial

Summary of Differences

	CURRENT PROCESS	NEW PROCESS
PROCESS ENTRY	▪ Claimant has limited or no program information available prior to entry. ▪ Claimant files by mail, telephone, or in-person	▪ Claimant has program information, starter application and means to gather evidence before entry ▪ Claimant files by mail, electronically, telephone or in-person
CLAIMS INTAKE	▪ Interview with claims representative trained only in nondisability aspects of program ▪ Multiple contacts with different claims specialists	▪ Interview with claim manager trained in disability and nondisability aspects of program ▪ Single point of contact for all claims processing
DISABILITY DECISION METHODOLOGY (Adult)	▪ 5-step sequential evaluation: — Engaging in substantial gainful activity — Severe impairment — Meets or equals the Listings of Impairments — Able to do past relevant work — Able to do other work (using the "Grid")	▪ 4-step approach: — Engaging in substantial gainful activity — Medically determinable impairment — Impairment is in Index of Disabling Impairments (No medical equivalence or assessing function) — Able to perform substantial gainful activity ("Grid" eliminated)

	CURRENT PROCESS	NEW PROCESS
DISABILITY DECISION METHODOLOGY (Child)	▪ 4-step sequential evaluation: — Engaging in substantial gainful activity — Severe impairment — Meets or equals Listings of Impairments — Comparable severity	▪ 4-step approach: — Engaging in substantial gainful activity — Medically determinable impairment — Impairment is in Index of Disabling Impairments (No medical equivalence or assessing function) — Comparable severity
EVIDENTIARY DEVELOPMENT	▪ SSA takes responsibility for obtaining medical evidence ▪ SSA obtains detailed clinical and laboratory findings in all claims ▪ SSA uses objective findings, medical opinion, and other evidence to assess a claimant's residual functional capacity	▪ Claimant is a partner in obtaining medical evidence ▪ SSA obtains evidence necessary to decide issues in the claim ▪ SSA, working with medical experts, develops standardized instruments and criteria for measuring a claimant's functional ability
INITIAL DISABILITY DETERMINATION	▪ Disability specialist and physician team decide claim based on paper review	▪ Claim manager decides claim after appropriate consultation with physician ▪ Claimant has opportunity for personal predenial interview
RECONSIDERATION	▪ Paper review by different disability specialist and physician team	▪ Reconsideration eliminated

	CURRENT PROCESS	NEW PROCESS
ADMINISTRATIVE LAW JUDGE HEARING	▪ Hearing request must be filed within 60 days of reconsideration ▪ ALJ is responsible for overseeing all prehearing development ▪ Prehearing conference is held in limited circumstances	▪ Hearing request must be filed within 60 days of initial determination. ▪ Adjudication officer oversees prehearing development ▪ Personal conference is mandatory if claimant is represented
APPEALS COUNCIL REVIEW	▪ Claimant requests Appeals Council review and the Appeals Council may consider new evidence ▪ Appeals Council action is a prerequisite for judicial review	▪ Appeals Council reviews claim only on its own motion; review is limited to the record before the ALJ ▪ Appeals Council action is not a prerequisite for judicial review
QUALITY ASSURANCE	▪ Quality measurements focus primarily on end-of-line disability decision accuracy; quality is not consistently measured at all levels of administrative review	▪ Quality assurance will address customer satisfaction, employee education/performance, and error prevention; end-of-line reviews will measure quality of the entire adjudicative process

	CURRENT PROCESS	NEW PROCESS
PROCESS INTEGRITY	▪ Adjudicative standards and policies are available through a variety of instructional vehicles ▪ Consistent training is not provided to disability decisionmakers	▪ A single policy book will be used by all adjudicators at all levels of administrative review ▪ Ongoing training will be provided to all disability decisionmakers and support personnel

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Detailed Description of New Process

Process Entry and Intake

SSA Will Customize Its Disability Claims Entry and Intake Processes to Maximize Access, Efficiency, Accuracy, and Personal Service

The disability claims entry and intake processes will reflect the SSA commitment to providing world-class service to the public. The hallmarks of the process will be accessible, personal service that ensures timely and accurate decisions. SSA will work to make potential claimants better informed about the disability process and fully prepare them to participate in it. SSA will also be flexible in providing modes of access to the claims process that best meet the needs of claimants and the third parties who act on their behalf. SSA will provide claimants with a single point of contact for all claims-related business. Finally, SSA will ensure that the disability decisionmaking process promotes timely and accurate decisions.

SSA Will Make Information About Its Disability Programs Available to Potential Claimants Prior to Entry Into the Process

SSA will make available to the general public comprehensive information packets about the Disability Insurance (DI) and Supplemental Security Income (SSI) disability programs. The packets will include information about the purpose of the disability programs; the definition of disability; the basic requirements of the programs; a description of the adjudication process; the types of evidence needed to establish disability; and the claimant's role in pursuing a claim.

SSA will make disability information packets commonly available in the community, both at facilities frequented by the general public (libraries, neighborhood resource centers, post offices, the Department of Veterans Affairs offices, and other Federal government installations) and at facilities frequented by potential claimants (hospitals, clinics, other health care providers, schools, employer personnel offices, State public assistance offices, insurance companies, and advocacy groups or third party organizations that assist individuals in pursuing disability claims). SSA studies have shown that claimants frequently rely on advice from their physicians and from State public assistance personnel in deciding whether to file a claim for disability benefits. Therefore, SSA will make a special effort to target its public information activities at these and other known sources of referrals for claims. SSA will also make the disability information packets available electronically.

In addition to comprehensive program information, the packets will describe the types of information that a claimant will need to have readily available when the individual files a claim. It will also contain two basic forms: the first, designed for completion by the claimant, will include general identifying information and will serve as the claimant's starter application for benefits; the second, designed for completion by the treating source(s), will request specific medical information about a claimant's alleged impairments. SSA will encourage claimants to review the information in the packet and have the basic forms completed prior to telephoning or visiting an SSA office to apply for disability benefits. Claimants filing will be encouraged to immediately submit starter applications to protect the filing dates for benefits. The starter application will serve as a claim for both programs, but it will include a disclaimer should the claimant want to preclude filing for benefits based on need (i.e., SSI).

SSA Will Permit Claimants to Choose the Mode of Entry Into the Process That Best Meets Their Individual Needs

The disability claims entry process will be multi-faceted, allowing claimants the maximum flexibility in deciding how they will participate in the process. Claimants may choose to enter the disability claims process by telephoning the SSA toll-free number, electronically, by mail, or by telephoning or visiting a local office. Claimants may also rely on third parties to provide them assistance in dealing with SSA. Finally, claimants may formally appoint representatives to act on their behalf in dealing with SSA. SSA field managers will also have the flexibility to tailor the various service options to their local conditions, considering the needs of client populations, individual claimants, and the availability of third parties who are capable of contributing to the application process.

If an individual submits a starter application by mail or electronically, SSA will contact the claimant to schedule an appointment for a claims

intake interview or, at the claimant's option, conduct an immediate intake interview by telephone.

If an individual telephones SSA to inquire about disability benefits, the SSA contact will explain the requirements of the disability program, including the SSA definition of disability, and provide a general explanation of evidence requirements. The SSA contact will determine whether the individual has the disability information packet, and mail it or advise the claimant regarding possible means of electronic access. If an individual indicates a desire to file a claim at that time, the SSA contact will complete the starter application available on-line as part of the automated claims processing system to protect the claimant's filing date and schedule an appointment for a claims intake interview. The interview may be in person or by telephone at the claimant's option. If the individual has no medical treating sources, the SSA contact will annotate this information within the on-line claim record.

If a claimant visits an SSA office, the SSA contact will refer the claimant for an immediate claims intake interview or, at the claimant's option, complete the starter application and schedule a future appointment for an intake interview.

In all cases, appointments for claims intake interviews will be made available within a reasonable time period, generally 3 to 5 working days, but no later than two weeks.

Local management will determine how to best accommodate claimants' needs in learning about the disability process and completing a claims intake interview. Depending on an individual's circumstances, such accommodation may involve: referral to the nearest location for obtaining an information packet which can then be mailed in; an immediate telephone or in-person interview; arranging for an on-site visit from an SSA representative; or referral to appropriate third parties who can provide assistance. Additionally, depending on the nature of the individual's disability, SSA may encourage the individual to file in person when it appears that a face-to-face interview will assist in the proper claims intake and development. Face-to-face interviews, when considered necessary by either the claimant or SSA, can also be accomplished via videoconferencing. In any case, SSA will make every reasonable effort to meet the needs of the claimant in completing the application process.

Similarly, local managers will modify the claims entry and intake process to provide maximum flexibility for representatives who act on behalf of claimants or third parties who can assist claimants in completing the application process. Such accommodations may include, but are not limited to: (1) Using automated means to interact with SSA to protect a claimant's date of filing (e.g., telephone, fax, or E-mail); (2) providing appointment slots for third parties to accompany claimants to interviews or to provide assistance during telephone claims on a claimant's behalf; (3) out-stationing SSA personnel at a third-party location to obtain applications and/or medical evidence, when appropriate; and (4) providing open appointment" scheduling to permit claimants to contact SSA within a flexible band of time. Interested third parties will be encouraged to participate in the development of claims by becoming certified by SSA to do so.

Local managers will also conduct outreach efforts that are designed to meet the needs of hard-to-reach populations or assist those individuals unable to access the SSA claims process without considerable intervention. As appropriate, outreach efforts may be facilitated through videoconferencing, teleconferencing or other electronic methods of obtaining and processing claims information to provide timely service despite claimants' geographic or social isolation.

A Disability Claim Manager Will Be Responsible for a Disability Claim From Intake Through Payment

A disability claim manager will have responsibility for the complete processing of an initial disability claim. The disability claim manager will be a highly-trained individual who is well-versed in both the disability and nondisability aspects of the program and has the necessary knowledge, skills, and abilities to conduct personal interviews, develop evidentiary records, and adjudicate disability claims to payment. However, the disability claim manager will also be able to call on other SSA resources such as medical and technical support personnel to provide advice and assistance in the claims process.

The disability claim manager will rely on an automated claims processing system that will permit the disability claim manager to: gather and store claims information; develop both disability and nondisability evidence; share necessary facts in a claim with SSA medical consultants and specialists in nondisability technical issues; analyze evidence and prepare well-rationalized decisions on both disability and nondisability issues; and produce clear and understandable notices that accurately convey all necessary information to claimants.

The disability claim manager will be the focal point for claimant contacts throughout the claim intake and adjudication process. The disability claim manager will explain the disability program to the claimant, including the definition of disability and how SSA determines if a claimant meets the disability requirements. The disability claim manager will also convey what the claimant will be asked to do throughout the process; what the claimant may expect from SSA during this process, including anticipated timeframes for decision; and how the claimant can interact with the disability claim manager to obtain more information or assistance. The disability claim manager will advise the claimant regarding the right to representation and provide the appropriate referral sources for representation. The disability claim manager will also advise the claimant regarding community resources, including the names of organizations that could help the claimant pursue the claim. The goal will be to give claimants access to the decisionmaker and allow for ongoing, meaningful dialogue between the claimant and the disability claim manager.

Claims Intake and Development Will Be Directed at Reaching a Decision in the Most Timely and Accurate Manner

The disability claim manager will conduct a thorough screening of the claimant's disability and nondisability eligibility factors. If the claimant appears ineligible for either disability program based on the claimant's allegations and evidence presented during the claim intake interview, the disability claim manager will explain this to the claimant. If the claimant decides not to file a claim, the disability claim manager will give the claimant an informal denial notice.

If the claimant decides to file, the disability claim manager will complete appropriate application screens from the automated claims processing and decision support system. Impairment-specific questions will assist the claim manager in obtaining information that is relevant and necessary to a disability decision. Based on the claimant's statements and the evidence that is available at that interview, the disability claim manager will determine the most effective way to process the claim. If the evidence is sufficient to decide the claim, the disability claim manager will take necessary action to issue a decision and, if necessary, effectuate payment. The disability claim manager will

determine what additional evidence is required to adjudicate the claim and will take steps to obtain that evidence. Such steps may include asking the claimant to obtain further medical or nonmedical evidence where feasible, requesting medical evidence directly from treating sources, or ordering further medical evaluations.

The disability claim manager will decide whether to defer nondisability development (e.g., requesting SSI income and resource information, or developing DI dependents' claims) or do it simultaneously with development of the disability aspects of the claim. In making this decision, the disability claim manager will take into account the type of disability alleged, evidence and other information presented by the claimant, and other relevant circumstances, e.g., terminal illness, homelessness or difficulty in recontacting the claimant. Because the disability claim manager maintains ownership of the claim throughout the initial decision-making process, the disability claim manager will be in the best position to choose the most efficient and effective manner of providing claimants with timely and accurate decisions while meeting claimants' individual service needs.

Although the disability claim manager will be responsible for the adjudication of an initial claim, the disability claim manager will call in other staff resources, as necessary. With respect to disability decisionmaking, the disability claim manager will, in appropriate circumstances, refer claims to medical consultants to obtain expert advice and opinion. Similarly, other staff resources will be called upon for technical support in terms of certain claimant contacts and status reports; development of nondisability issues including auxiliary claims or representative payee issues; and payment effectuation. However, the disability claim manager will make final decisions on both the disability and nondisability aspects of the claim.

Claimants Will Be Partners in the Processing of Their Disability Claims

Throughout the disability claims process, SSA will encourage claimants to be full partners in the processing of their claims. To the extent that they are able, claimants and their families and other personal support networks will actively participate in the development of evidence to substantiate their claim for disability benefits. SSA will provide assistance and/or engage third party resources, when necessary and appropriate. SSA will keep claimants informed of the status of their claims, advise claimants regarding what additional evidence may be necessary, and inform claimants what, if anything, they can do to facilitate the process.

At the completion of the claims intake interview, the disability claim manager will issue a receipt to the claimant that will identify what to expect from SSA and the anticipated timeframes. It will also identify what further evidence or information the claimant has agreed to obtain. Finally, it will provide the name and telephone number of the disability claim manager for any questions or comments which the claimant may have.

SSA Will Recognize That Some Third Parties Can Develop Complete Application Packages

Certain third party organizations may be willing to provide a complete disability application package to SSA. Based on local management's assessment of service area needs and the availability of qualified organizations, SSA will certify third party organizations who are capable of providing a complete application package, including appropriate application forms and medical evidence necessary to adjudicate a disability claim. In such claims, SSA will permit the third party to identify potential claimants, screen for disability and nondisability criteria, and contact SSA to protect the filing date. The third party will interview the claimant; complete all applications and related forms; obtain completed treating source statements; and obtain additional medical evaluations, when appropriate. Using procedures agreed on with local management, the third party will submit claims for adjudication by a disability claim manager. The disability claim manager may elect to contact the claimant for the purpose of verifying identity or other claims-related issues, as appropriate. SSA will monitor such third parties to ensure that quality service is provided to claimants and to prevent fraud.

Claimants Will Have the Opportunity for a Personal Interview Before SSA Makes an Initial Disability Denial Decision

When the evidence does not support an allowance, the disability claim manager will provide the claimant an opportunity for a personal interview before issuing the initial denial determination. The interview will be in person, by videoconference, or by telephone, at the claimant's option and as the disability claim manager determines is appropriate under the circumstances. In appropriate circumstances, the predenial interview may follow the initial intake interview. The purpose of the predenial interview will be to advise the claimant of what evidence has been considered and to identify what further evidence, if any, is available that bears on the issues. If such further evidence exists, the disability claim manager will advise the claimant to obtain the evidence or, as appropriate, assist the claimant in obtaining it.

Initial Disability Decisions Will Use a "Statement of the Claim" Approach

The initial disability determination will use a "statement of the claim" approach. The statement of the claim will set forth the issues in the claim, the relevant facts, the evidence considered, including any evidence or information obtained during the predenial interview, and the rationale in support of the determination. The statement of the claim not only reflects the SSA commitment to fully explaining the basis for its action but also recognizes that claimants need clear information about the basis for the determination to make an informed decision regarding further appeal.

Much of the information that will provide the basis for the statement of the claim will be available on-line as part of the automated claims processing and decision support system. Adjudicators will create the statement of the claim and whatever supplementary information is necessary for a legally sufficient notice to the claimant based on the information in the decision support system. For allowance decisions, the statement of the claim will be more abbreviated than for denial decisions; however, it will contain sufficient information to facilitate quality assurance reviews and/or continuing disability reviews. The statement of the claim will be part of the on-line claim record and will be available to other adjudicators as the basis and rationale for the Agency action, if the claimant seeks further administrative review.

Disability Decision Methodology

The Methodology for Deciding Disability Claims Will Promote Consistent, Equitable, and Timely Disability Decisions

SSA must have a structured approach to disability decisionmaking that takes into consideration the large number of claims (2.7 million initial disability decisions in FY 1994) and still provides a basis for consistent, equitable decisionmaking by adjudicators at each level. The approach must be simple to

administer, facilitate consistent application of the rules at each level, and provide accurate results. It must also be perceived by the public as straightforward, understandable and fair. Finally, the approach must facilitate the issuance of timely decisions.

The cornerstone of any approach is, of course, the statutory definition of disability. Under the statute, disability (for adults) means the: "* * * inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months * * * An individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy * * *" (section 223(d) of the Social Security Act)

The decision-making approach is the foundation on which SSA will base the claim intake process and evidence collection. The focus will be, first, to establish a solid medical basis for documenting that an individual has a medically determinable physical or mental impairment. Second, once the evidence establishes a medically determinable impairment, SSA will use additional medical findings to provide a solid link between the disease entity and the loss of function caused by the impairment(s).

Disability Decisionmaking for Adult Claims Will Be a Four-Step Evaluation Process

The disability decision methodology will consist of four steps that are based on the statutory definition of disability. They are:

Step 1—Is the individual engaging in substantial gainful activity?
If yes, deny.
If no, continue to Step 2.
Step 2—Does the individual have a medically determinable physical or mental impairment?
If no, deny.
If yes, continue to Step 3*.
Step 3—Does the individual have an impairment that is included in the Index of Disabling Impairments?
If yes, allow*.
If no, continue to Step 4.
Step 4—Does the individual have the functional ability to perform substantial gainful activity?
If yes, deny.
If no, allow*.

*An impairment must meet the duration requirement of the statute; a denial is appropriate for any impairment that will not be disabling for 12 months.

Step 1—Engaging in Substantial Gainful Activity

Any individual who is engaging in substantial gainful activity will not be found disabled regardless of the severity of the individual's physical or mental impairments. If a claimant is performing substantial gainful activity at the time a claim is filed, SSA will determine that the claimant is not disabled based on the demonstrated ability to engage in substantial gainful activity.

Under the current process, in determining whether a claimant is performing or has performed substantial gainful activity, SSA generally considers the amount of the claimant's earnings, less any impairment-related work expenses. However, there are several threshold levels of earnings that need to be considered and, depending on the actual amount earned, SSA evaluates whether a claimant's work is comparable to that of unimpaired individuals in the community who are doing the same or similar occupations, or whether the work is substantial gainful activity based on prevailing pay scales in the community.

Under the new process, SSA will simplify the monetary guidelines for determining whether an individual (except those filing for benefits based on blindness) is engaging in substantial gainful activity. In making this determination, SSA will evaluate the work activity based on the earnings level that is comparable to the upper earnings limit in the current process (i.e., $500). A single earnings level will simplify the evidentiary development necessary to evaluate work activity and establish the appropriate onset date of disability. SSA will continue to exclude impairment-related work expenses in evaluating whether a claimant's earnings constitute substantial gainful activity. SSA will continue to use separate earnings criteria to evaluate the work activity of blind individuals as in the current process.

Step 2—Medically Determinable Impairment

Because the statute requires that disability be the result of a medically determinable physical or mental impairment, the absence of a medically determinable impairment will justify a finding that the individual is not disabled.

Under the current regulations, SSA considers, as a threshold matter, whether an individual has a medically determinable impairment or combination of impairments that is "severe." A severe impairment is defined as one that significantly limits the individual's physical or mental abilities to do work activities such as walking, standing, sitting, hearing, seeing, understanding, carrying out, or remembering simple instructions, using judgment, etc.

Under the new approach, SSA will consider whether a claimant has a medically determinable impairment, but will no longer impose a threshold severity requirement. Rather, the threshold inquiry will be whether the claimant has a medically determinable physical or mental impairment. To establish the presence of a medically determinable impairment, evidence must show an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

SSA will continue to evaluate the existence of a medically determinable impairment based on a weighing of all evidence that is collected, recognizing that neither symptoms nor opinions of treating physicians alone will support a finding of disability. There must be medical signs and findings established by medically acceptable clinical or laboratory diagnostic techniques which show the existence of a physical or mental impairment that results from anatomical, physiological, or psychological abnormalities which, *in the opinion of the Secretary*, could reasonably be expected to produce the symptoms or substantiate any opinion evidence provided. Depending on the nature of a claimant's alleged impairments, SSA will consider the extent to which medical personnel other than physicians can provide evidence of a medically determinable impairment.

There will be an exception to the requirement that evidence include medically acceptable clinical and/or laboratory diagnostic techniques. This will occur when, even if SSA accepted all of the claimant's allegations as true, SSA still could not establish a period of disability; under these circumstances, SSA will not require evidence to establish the existence of a medically determinable impairment. For instance, if a claimant describes a condition as one that will clearly not meet the 12-month duration requirement, (e.g., a simple fracture), SSA will deny the claim on the basis that even if the allegations were medically documented, SSA could not establish a period of disability.

Step 3—Index of Disabling Impairments

If an individual has a medically determinable physical or mental impairment documented by medically acceptable clinical and laboratory techniques, and the impairment will meet the duration requirement, SSA will compare the claimant's impairment(s) against an index of severely disabling impairments. In contrast to the Listing of Impairments in the current regulations, the index will contain fewer impairments and have less detail and complexity. The index will describe impairments that will result in death or impairments that are so debilitating that any individual would be unable to engage in substantial gainful activity regardless of any reasonable accommodations that an employer might make in accordance with the Americans with Disabilities Act. The index will be designed to be equitable, easy to understand, and consistent with the statutory definition of disability.

The index will function to quickly identify severely disabling impairments; the index will not attempt to describe ideal medical documentation requirements for each and every body system as occurs with the current Listings. The index will consist of descriptions of specific impairments and the medical findings that are used to substantiate the existence and severity of the particular disease entity. The index will not attempt to measure the functional impact of an impairment on the individual; functional impact will be considered at Step 4 in the process. The medical findings in the index will be as nontechnical as possible and will exclude such things as calibration or standardization requirements for specific tests and/or detailed test results (e.g., pulmonary function studies or electrocardiogram tracings). The index will be simple enough so that laypersons will be able to understand what is required to demonstrate a disabling impairment in the index. Additionally, SSA will draw no inferences or conclusions about the effect of a claimant's impairments on his or her ability to function merely because a claimant's impairment(s) does not meet the criteria in the index. Finally, SSA will no longer use the concept of medical equivalence" in relation to the index, as it now uses in applying the Listing of Impairments.

Step 4—Ability to Engage in Any Substantial Gainful Activity

In the final step in determining disability, SSA will consider whether an individual has the ability to perform substantial gainful activity despite any functional loss caused by a medically determinable physical or mental impairment. If an individual retains the ability to perform substantial gainful activity, then an individual does not meet the statutory definition of disability.

Presently, there are no generally accepted measurement criteria for determining an individual's ability to function in relation to work-related activities. Currently, SSA assesses residual functional capacity by analyzing the objective medical findings and other available evidence and translating this information into functional loss and residual capacity for work activities.

Additionally, there are also no definitive sources for identifying the physical and mental requirements of "baseline" work functions that are required to engage in substantial gainful activity. SSA currently relies on the Department of Labor definitions regarding the physical and mental demands of work in the national economy, and relies on related reference sources and independent experts regarding the existence of particular occupations and jobs in the national economy.

Under the new process, SSA will define the physical and mental requirements of substantial gainful activity and, will measure as objectively as possible whether an individual meets these requirements. How SSA will achieve this is described in the following sections.

SSA Will Develop Instruments That Provide A Standardized Measure of Functional Ability

Under the current process, SSA relies on available clinical and laboratory findings, treating source opinions, the claimant's description of his or her abilities and limitations, and third party observations of the claimant's limitations in determining the claimant's residual functional capacity. Residual functional capacity is the claimant's remaining capacity for work activities despite the limitations or functional loss caused by his or her impairments.

Under the new process, SSA will develop, with the assistance of the medical community and other outside experts from public and private disability programs, standardized criteria which can be used to measure an individual's functional ability. These standardized measures of functional ability will be linked to clinical and laboratory findings to the extent that SSA needs to document the existence of a medically determinable impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the functional loss. However, extensive development of all available clinical and laboratory findings is not necessarily effective in evaluating an individual's functional ability to perform basic work activities.

Functional assessment instruments will be designed to measure, as objectively as possible, an individual's abilities to perform a baseline of occupational demands that includes the principal dimensions of work and task performance, including primary physical, neurophysical, psychological, and cognitive processes. Examples of task performance include, but are not limited to: Physical capabilities, such as sitting, standing, walking, lifting, pushing, pulling; mental capabilities, such as understanding, carrying out, and remembering simple instructions; using judgment; responding appropriately to supervisors and co-workers in usual work situations; and responding appropriately to changes in the routine work setting; and postural and environmental limitations. Functional assessment instruments will be designed to realistically assess an individual's abilities to perform a baseline of occupational demands.

SSA will be primarily responsible for documenting functional ability using the standardized measurement criteria. In the near term, SSA will solicit functional information from treating medical sources, other nonmedical sources, and from claimants in a manner that is similar to the current process. In the future, the standardized measurement criteria will be widely available and accepted so that functional assessments may be performed by a variety of medical sources, including treating sources. The SSA goal will be to develop functional assessment instruments that are standardized, that accurately measure an individual's functional abilities and that are universally accepted by the public, the advocacy community, and health care professionals. Ultimately, documenting functional ability will become the routine practice of physicians and other health care professionals, such that a functional assessment with history and descriptive medical findings will become an accepted component of a standard medical report.

The prospect of universal health coverage may offer a unique opportunity for SSA to work with the public and private sector to develop standards that both can use. For example, medical

insurance payors (whether public or private) may want some way of measuring the effectiveness and necessity of treatment that is prescribed by the individual's treatment source; SSA will want these same types of measures to determine how well an individual is able to function despite his or her impairment(s). Similarly, if all individuals have treating sources under universal health coverage, SSA can expect that complete functional assessment measurements will be readily available from a treating source. Finally, universal health coverage may enable SSA to access medical records from health care providers who may be operating under some contractual or other relationship with Federal agencies and/or a statutory requirement that health care providers cooperate in providing evidence as a condition of receiving Federal funds.

SSA will use the results of the standardized functional measurement in conjunction with a new standard that SSA will develop to describe basic physical and mental demands of a baseline of work that represents substantial gainful activity and that exists in significant numbers in the national economy.

SSA Will Identify Baseline Occupational Demands That Represent Substantial Gainful Activity

Under the current regulations, after assessing a claimant's residual functional capacity, SSA evaluates whether the claimant can meet the physical and mental demands of his or her past relevant work. Past relevant work is usually work that a claimant performed in the last 15 years.

If the claimant is unable to perform his or her past work, SSA then evaluates whether the claimant can perform other work in the national economy. In making this decision, SSA relies on medical-vocational guidelines (the "Grid"). The Grid rules represent major functional and vocational patterns and reflect the analysis of various vocational factors (age, education and work experience) in combination with the claimant's residual functional capacity (which is used to determine the claimant's maximum sustained work capacity for sedentary, light, medium, heavy or very heavy work).

In promulgating the Grid rules, SSA has taken administrative notice of the existence of unskilled jobs that exist in the national economy at the various functional levels. Therefore, when all the findings of fact regarding a claimant's functional ability and vocational factors coincide with the corresponding criterion of a rule, the existence of other work in the national economy is conclusively established. However, if any finding of fact does not coincide with the criterion of a rule, the rules can only provide a framework for decisionmaking. In these situations, adjudicators must consult vocational resources or obtain expert testimony to resolve the question of whether other work exists in the national economy that the claimant can perform.

Under the new approach, SSA will conduct research and, working in conjunction with outside experts, will specifically identify the activities that comprise a baseline of occupational demands needed to perform substantial gainful activity. In the current process, an example of comparable "baseline" criteria are the functional requirements of unskilled, sedentary work. In establishing the functional activities that comprise an appropriate baseline of occupational demands, SSA will ensure that:

(1) The functional activities are a realistic reflection of the demands of occupations that exist in significant numbers in the national economy;

(2) The occupations are those that can be performed in the absence of prior skills or formal job training; and

(3) The baseline of occupational demands that becomes the standard for evaluating the ability to perform substantial gainful activity considers any reasonable accommodations that employers are expected to make under the Americans with Disabilities Act.

The Effect of Age on Ability to Perform Substantial Gainful Activity

The effect of aging on the ability to perform substantial gainful work is very difficult to measure, especially in the context of today's world when individuals are living longer than preceding generations. Despite this change, the demographic characteristics of those preceding generations continue to provide the framework for disability decisionmaking because SSA's approach for deciding disability has changed little since the inception of the DI program.

The statute recognizes that age should be considered in assessing disability on the assumption that the ability to make a vocational adjustment to work other than work an individual has previously done may become more difficult with age. In determining the impact of age, recognition should be given to the changes that occur with each succeeding generation. Accordingly, in the new process, SSA will establish age criterion in relation to the full retirement age. The full retirement age will gradually increase over time, based on the recognition that succeeding generations can expect to remain in the workforce for longer periods than the preceding generation.

In applying age criterion under the new process, an individual who falls within the prescribed number of years preceding the full retirement age will be considered as "nearing full retirement." In establishing what the prescribed number of years should be, SSA will conduct research and consult with outside experts on the relationship between age and an individual's ability to make vocational adjustments to work other than work the individual has done in the recent past.

SSA will rely on the age of the individual in relation to the full retirement age to decide which of two decision paths to follow as described in the next two sections.

Individuals Who Are Not Nearing Full Retirement

For an individual who is not nearing full retirement, SSA will compare the individual's functional abilities against the functional demands of the baseline work. SSA will no longer rely on the medical-vocational guidelines and/or expert testimony to identify whether work exists in the national economy that the claimant can perform. The ability to perform the baseline work will represent a realistic opportunity to perform substantial gainful activity that exists in significant numbers in the national economy and a finding of disability will not be appropriate.

However, anyone, regardless of age, who cannot perform the baseline work will be considered unable to engage in substantial gainful activity, and a finding of disability will be justified. The range of work represented by less than the baseline will be considered so narrow that despite any other favorable factors, such as young age or higher education or training, an individual would not be expected to have a realistic opportunity to perform substantial gainful work in the national economy.

For individuals who are not nearing full retirement, the ability or inability to perform previous work is not a significant factor. These individuals should be capable of making a vocational adjustment to other work, as long as they are functionally capable of performing the baseline work.

Individuals Who Are Nearing Full Retirement

For individuals who are nearing full retirement, SSA will compare the individual's functional abilities against the functional demands of the

individual's previous work. Individuals nearing full retirement age can not be expected to make a vocational adjustment to work other than work they have performed in the recent past. However, consistent with the statute, if an individual, even one nearing full retirement age, is capable of performing his or her previous work, SSA will find that the individual is not disabled.

For those individuals who have no previous work, SSA will compare the individual's functional abilities to the baseline work, and a finding of not disabled will be appropriate if the individual is capable of performing the baseline work. In such claims, the fact that the individual has no previous work is usually not related to the existence of his or her impairment(s), and a finding of disability will not be appropriate for these individuals if they retain the capacity for the baseline work.

The Effect of Education on Ability to Perform Substantial Gainful Activity

The statute also recognizes that education may play a role in an individual's ability to perform substantial gainful activity. Experience demonstrates that educational level alone, i.e., the numerical grade level that an individual has attained may not be a good indicator of ability to function. Education is generally completed in the remote past when compared to the age at which the majority of disability claimants file for benefits. Completion of a certain educational level in the remote past, without any practical application of that education in recent work activity, has no positive effect on an individual's ability to perform substantial gainful activity.

In relying on standardized functional assessments, SSA will be measuring both the individual's physical and mental abilities, and education will be appropriately reflected in the assessment of an individual's cognitive abilities. However, further evaluation of a claimant's educational level will not be required because, in establishing the functional activities that comprise an appropriate baseline of occupational demands, SSA will not assume that individuals have prior skills or significant formal job training. Thus, additional formal education will have little impact on an individual's ability to perform the baseline of occupational demands.

SSA Will Rely on Medical Consultants to Provide Necessary Expertise in the Decisionmaking Process

SSA will continue to rely on medical consultants to provide expert advice and opinion regarding medical questions and issues that will arise in deciding disability claims. Disability adjudicators at all levels of the administrative review process will call on the services of medical consultants to interpret medical evidence, analyze specific medical questions, and provide expert opinions on existence, severity and functional consequences of medically determinable impairments. If a medical consultant is called on to offer expert advice and opinion, the medical consultant will provide a written analysis of the issues and rationale in support of his or her opinion. The written analysis will be included in the record and will be considered with the other medical evidence of record by disability adjudicators at all levels of administrative review. Additionally, medical consultants will assist in the training of other consultants and disability adjudicators; contact other health care professionals to resolve medical questions on specific claims; perform public relations and training with the medical community; and participate in SSA quality assurance efforts.

Childhood Disability Methodology

As with adults, SSA must have a structured approach to disability decisionmaking in childhood claims that takes into consideration the relatively large number of claims and still provides a basis for consistent, equitable decisionmaking by adjudicators at all levels of administrative review. The approach for childhood claims must also derive from the statute. Under the statute,

> An individual will be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity). (Section 1614(a)(3)(A) of the Social Security Act).

Disability Decisionmaking For Childhood Claims Will Be a Four-Step Evaluation Process

The disability decision methodology for childhood claims will consist of four steps that are based on the statutory definition of disability.

As with adults, the approach is one that provides accurate decisions that can be achieved efficiently and cost-effectively, primarily by ensuring that documentation requirements are directed toward the ultimate finding of disability. The four steps are:

Step 1—Is the child engaging in substantial gainful activity?
If yes, deny.
If no, continue to Step 2.
Step 2—Does the child have a medically determinable physical or mental impairment?
If no, deny.
If yes, continue to Step 3*.
Step 3—Does the child have an impairment that is included in the Index of Disabling Impairments?
If yes, allow *.
If no, continue to Step 4.
Step 4—Does the child have the functional ability to perform activities that are comparable to an adult's ability to engage in substantial gainful activity?
If yes, deny.
If no, allow *.

* An impairment must meet the duration requirement of the statute; a denial is appropriate for any impairment that will not be disabling for 12 months.

Step 1—Engaging in Substantial Gainful Activity

Any child who is engaging in substantial gainful activity will not be found disabled regardless of the severity of his or her physical or mental impairments. The guidelines for determining whether a child is engaging in substantial gainful activity will be identical to the guidelines for adults. Although the issue of work activity will arise infrequently in childhood claims, the step is warranted for two reasons:

(1) The approach for adults and children should be as similar as possible; and

(2) As a child approaches age 18, it is increasingly likely that work activity may be an issue.

Step 2—Medically Determinable Impairment

Because the statute requires that disability be the result of a medically determinable physical or mental impairment, the absence of a medically determinable impairment will justify a finding that a child is not disabled. To establish the presence of a medically determinable impairment, evidence must show an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

The same guidelines and rules that apply for adults will apply equally for children. SSA will continue to evaluate

the existence of a medically determinable impairment based on a weighing of all evidence that is collected, recognizing that neither symptoms nor opinions of treating physicians alone will support a finding of disability. There must be medical signs and findings established by medically acceptable clinical or laboratory diagnostic techniques which show the existence of a physical or mental impairment that results from anatomical, physiological, or psychological abnormalities which, *in the opinion of the Secretary*, could reasonably be expected to produce the symptoms or substantiate any opinion evidence.

SSA will use the same exception for evidence collection in childhood claims that will be applied in adult claims. If a child has a medically determinable physical or mental impairment that is not an exception to further development, SSA will then evaluate whether the impairment(s) is included in the index of disabling impairments.

Step 3—Index of Disabling Impairments

If a child has a medically determinable physical or mental impairment documented by medically acceptable clinical and laboratory techniques and the impairment will meet the duration requirement, SSA will compare the child's impairment(s) against an index of disabling impairments. As with adults, the index for childhood claims will function to quickly identify severely disabling impairments; the index will not attempt to describe ideal medical documentation requirements for each and every body system.

The index for childhood claims will consist of descriptions of specific impairments and the medical findings that are used to substantiate the existence and severity of the particular disease entity. As with adults, the childhood index will not attempt to measure the functional impact of an impairment on the child; functional impact will be considered at Step 4 in the process. The medical findings in the index will be as nontechnical as possible and will be simple enough so that laypersons will be able to understand what is required to substantiate a disabling impairment in the index. As with adults, SSA will draw no inferences or conclusions about the effect of a child's impairments on his or her ability to function merely because a child's impairment(s) is not included in the index. Additionally, SSA will no longer use the concept of medical equivalence" or functional equivalence in relation to the childhood Index.

Step 4—Comparable Severity to Adult Ability to Engage in Substantial Gainful Activity

In evaluating disability in adults, SSA will evaluate an individual's functional ability to perform work-related activities consistent with the ability to engage in any substantial gainful activity. The difficulty with evaluating childhood claims is the standard against which any functional measurement criteria are compared. For older children, it is relatively easy because at some age (somewhere between 14 and 18) the standard approaches the adult standard, i.e., ability to engage in substantial gainful activity. However, for younger children, the standard can be more difficult to describe. Under the current process, SSA uses a standard that measures the degree to which a child engages in age-appropriate activities which corresponds fairly well with developmental milestones for different age categories. However, the difficulty with this approach is that it may not appropriately define how much functional loss or interference with growth and maturity is comparable to inability to perform any substantial gainful activity.

Consistent with the adult approach, SSA will develop baseline criteria for a child's activities that are comparable to an adult's ability to perform substantial gainful activity. In establishing a baseline of functional activities, the functional abilities for a child will represent a realistic comparison to an adult's ability to work.

Functional Assessment Instruments

Consistent with the approach for adult claims, SSA will develop, with the assistance of the medical community and educational experts, standardized criteria which can be used to measure a child's functional ability. These standardized measures of functional ability will be linked to clinical and laboratory findings to the extent that SSA needs to document the existence of a medically determinable impairment that results from anatomical, physiological, or psychological abnormalities which could reasonably be expected to produce the functional loss.

These functional assessment instruments will be designed to measure, as objectively as possible, a child's abilities to perform a baseline of functions that are comparable to the baseline of occupational demands for an adult. SSA will conduct additional research to specifically identify activities that are comparable to those that comprise a baseline of occupational demands needed to perform substantial gainful activity by adults.

SSA will be primarily responsible for documenting functional ability using the standardized measurement criteria. Ultimately, the course of documenting and developing for the functional abilities for childhood claims will mirror the adult approach.

Comparability Standard

SSA will develop realistic standards which represent activities that are comparable to an adult's ability to engage in substantial gainful activity. The standards will focus on a skill acquisition threshold designed to measure broad areas of skill that are required to ultimately develop the ability to engage in substantial gainful activity. If the child is progressing satisfactorily in the development of these skills, then the child will not have an impairment of comparable severity and SSA will not find the child disabled.

Evidentiary Development

SSA's Ability To Issue Timely and Accurate Disability Decisions Depends on the Efficient Collection of Quality Medical Evidence

SSA's ability to provide timely and accurate disability decisions depends to a significant degree on the quality of medical evidence it can obtain and the speed with which it can obtain it. The medical evidence collection process accounts for a considerable portion of the total time involved in processing disability claims.

Traditionally, the procurement of medical evidence has involved multiple, often repetitive, requests for information from a variety of health care providers. Health care providers believe that these requests burden them with far too much paperwork and offer far too little in the way of compensation for the time invested. Conversely, adjudicators often find that this evidence is primarily treatment-oriented and fails to provide the highly specialized clinical information required by the current Listings, or the functional information that is frequently necessary at various points in disability decision-making process. Health care professionals, particularly physicians, readily concede that their training is oriented towards diagnosis and treatment, not the assessment of function. Thus, the timely collection of medical information depends to a significant degree on health care providers who have only a tangential interest and understanding of

the disability program, its requirements, and, most importantly, the vital role that health care providers' information has in the disability decision process.

Evidence Collection Will Focus on Core Diagnostic and Functional Information Necessary to a Disability Decision

The goals of the evidence collection process will be to focus requests for evidence on the critical diagnostic and functional assessment information necessary for a disability decision and to form a new partnership with the sources of this information so that it can be obtained in the most efficient, cost-effective manner. Medical evidence development will be driven by the four-step approach SSA will use to decide disability. Two of the core elements of that approach are: (1) Identifying an individual's medically determinable impairments (including those that meet the Index of Disabling Impairments criteria); and (2) assessing the functional consequences of those impairments. SSA will develop medical evidence that is sufficient to satisfy the core elements but target evidentiary development so that SSA obtains only the evidence that is necessary to reach an accurate decision on the ultimate question of disability.

Treating Sources Will be the Preferred Sources for Medical Evidence

SSA will give primary emphasis to obtaining medical information from treating sources by way of brief, but specific, diagnostic information regarding an individual's medically determinable impairments and the functional consequences of those impairments. Treating source statements will include diagnostic information about a claimant's impairments, the clinical and laboratory findings which provide the basis for the diagnosis, onset and duration, response to treatment, and the functional limitations that can reasonably be linked to the clinical and laboratory findings. SSA will develop, in conjunction with the appropriate health care professionals and other public and private disability programs, standardized criteria which can be used to measure, as accurately and objectively as possible, an individual's functional ability. SSA will also seek health care providers' assistance in educating the medical community on the clinical application of these instruments. Once developed and universally accepted as the appropriate standard by the medical community, the standardized measurement criteria will be widely available. If a standardized functional assessment is available from a treating source, SSA will obtain that information and accept it as probative evidence. SSA may also request that the treating source or another examining source perform the standardized functional assessment at SSA expense.

SSA Will Use a Standardized Form To Request Medical Evidence From Treating Sources

SSA will develop a standardized form which effectively tailors the request for evidence to the specific diagnostic and functional assessment information necessary to make a disability decision. The standard form will also be available in electronic form to permit treating sources to submit evidence electronically. Standardizing requests for evidence in this manner will facilitate the participation of claimants, representatives and third parties in the evidence collection process.

The form will permit treating sources to provide necessary diagnostic and functional assessment information on a single document. In appropriate circumstances, SSA will accept a treating source's statement on the standardized form as to these issues without resorting to the traditional, wholesale procurement of actual medical records. Depending on the nature and extent of an individual's impairments and treating sources, statements from multiple medical sources may be appropriate. In completing standard forms, treating sources will certify that they have in their possession the medical documentation referred to in the statement and that said documentation will be promptly submitted at the request of SSA. The certification approach is consistent with evidence collection methods used by private disability insurance carriers, which request specific medical records in individual claims, as appropriate to the individual circumstances, or at random as part of a quality assurance program. SSA will monitor treating source completion of the standardized forms and verify evidence when appropriate.

SSA Will Provide Incentives for Treating Sources To Cooperate in the Development of Medical Evidence

SSA will acknowledge the value of treating source information by establishing a national fee reimbursement schedule for medical evidence. Additionally, the fee reimbursement schedule will utilize a sliding-scale mechanism to reward the early submission of medical information. A national, sliding-scale fee schedule will provide incentives for treating sources to cooperate in the evidentiary development process and invest quality time to provide medical certifications on behalf of their patients.

SSA will focus professional educational efforts and medical relations outreach at the local and/or regional level to ensure that treating sources are kept informed of program requirements and made aware of specific evidentiary needs or problems as they arise in the adjudication process.

SSA Will Use Consultative Examinations When There is No Treating Source Able or Willing To Provide Necessary Evidence or There Are Unresolved Conflicts in the Record

If a claimant has no treating source, or a treating source is unable or unwilling to provide the necessary evidence, or there is conflict in the evidence that can not be resolved through evidence from treating sources, SSA will refer the claimant for an appropriate consultative examination. Because the standardized measurement criteria for assessing function will be widely available, consulting sources will be able to perform functional assessments that, in the absence of adequate treating source information or where there are unresolved conflicts in the evidence, will be considered probative evidence. Depending on the service area, SSA will consider contracting with large health care providers to furnish consultative examinations for a specified geographic location.

As part of an ongoing training and medical relations program, SSA will ensure that providers of consultative examinations are provided adequate training on disability requirements, both initially and as program changes occur.

Administrative Appeals Process

The Administrative Appeals Process Will Be Simple and Accessible and Maintain Public Confidence in the Integrity of the Process

The administrative appeals process will be simplified to increase the accessibility of the process. The public perceives multiple, mandatory appeal steps as obstacles to receiving timely, fair, and accurate decisions. SSA will reduce the number of mandatory appeals steps in the administrative process. Streamlining the appeals process in this manner will not only promote more timely decisions but also ensure that claimants do not inappropriately withdraw from the claims process based on a perception that it is too difficult or time-consuming to pursue their appeal rights.

Claimants will be able to fully participate in the administrative appeals

process with or without a representative. SSA will ensure that claimants are fully advised of their right to representation and SSA will routinely provide the appropriate referral sources for representation. SSA will also encourage the early participation of a representative when the claimant has appointed one and will give the representative responsibility for developing evidence necessary to decide a claim. However, the decision whether to appoint a representative must remain with the claimant and SSA will neither encourage nor discourage claimants in seeking representation.

The administrative appeals process will function so that it maintains the public's confidence in the integrity of the system. To instill such confidence, SSA will provide an initial decisionmaking process that is thorough and results in fully developed records with fair and accurate decisions. Additionally, SSA will explain the basis of a decision in clear and understandable language. Finally, SSA will ensure that disability claims are decided on the merits of the evidence and that SSA regulations and policies have been consistently applied at all levels of administrative review.

As noted previously, the initial disability determination will use a "statement of the claim" approach which will set forth the issues in the claim, the relevant facts, the evidence considered, including any evidence or information obtained during the predenial interview, and the rationale in support of the determination. The statement of the claim will be part of the on-line claim record and will stand as the basis and rationale for the Agency action, if the claimant seeks further administrative review. SSA will standardize claim file preparation and assembly, including the use of appropriate electronic records, at all levels of administrative process until such time as the claims record is fully electronic.

The Next Level of Administrative Appeal Will Be an Administrative Law Judge Hearing

Because the initial determination will be the result of a process that ensures fully developed evidentiary records and ample opportunity for the claimant to personally present additional evidence prior to an adverse determination, there will be no need for any intermediate appeal (e.g., reconsideration) prior to the administrative law judge (ALJ) hearing. If the claimant disagrees with the initial determination, the claimant may, within 60 days of receiving notice, request an ALJ hearing.

An Adjudication Officer Will Conduct All Prehearing Proceedings

If a claimant decides to request an ALJ hearing, an adjudication officer will conduct an interview in person, by telephone, or by videoconference, and become the primary point of contact for the claimant. The adjudication officer will have the same knowledge, skills and abilities as the adjudicators who decide claims initially. The adjudication officer will also have specialized knowledge regarding hearings and appeals procedures. The adjudication officer will be the focal point for all prehearing activities but will be expected to work closely with the ALJ, medical consultants and the disability claim manager, when appropriate. The adjudication officer will explain the hearing process; advise the claimant regarding the right to representation; provide the appropriate referral sources for representation; give the claimant, where appropriate, copies of necessary claim file documents to facilitate the appointment of a representative; and encourage the claimant to decide about the need for and choice of a representative as soon as is practical.

The adjudication officer will also identify the issues in dispute and whether there is a need for additional evidence. If the claimant has a representative, the representative will have the responsibility to develop evidence. The adjudication officer will also conduct informal conferences with the representative, in person or by telephone, to identify the issues in dispute and prepare written stipulations as to those issues not in dispute. If the claimant submits additional evidence, the adjudication officer may refer the claim for further medical consultation, as appropriate. The adjudication officer will have full authority to issue a revised favorable decision if the evidence so warrants. If the adjudication officer issues a favorable decision, the adjudication officer will refer the claim back to the disability claim manager to effectuate payment.

The adjudication officer will consult with the ALJ during the course of prehearing activities, as necessary and appropriate to the circumstances in the claim. As a preliminary matter, the adjudication officer will also set a date for the hearing that is 45 days after the hearing request. The adjudication officer may exercise discretion in establishing an earlier or later hearing date depending on the individual circumstances. Electronic access to ALJs' calendars will facilitate timely scheduling of hearings. The adjudication officer will refer the prepared record to an ALJ only after all evidentiary development is complete and the claimant or a representative agrees that the claim is ready to be heard.

The ALJ will retain the authority and ability to develop the record. However, use of an adjudication officer realigns most, if not all, prehearing activities so that the burden of ensuring their completion rests with other members of the adjudicative team. ALJs' primary function will be hearing and deciding claims.

The Administrative Law Judge Hearing Will be a De Novo, Nonadversarial Proceeding

The ALJ hearing will be a *de novo* proceeding in which the ALJ considers and weighs the evidence and reaches a new decision.

A *de novo* hearing is consistent with the role of an ALJ envisioned under the Administrative Procedure Act. Under that scheme, the ALJ is an independent decisionmaker who must apply an agency's governing statute, regulations and policies, but who is not subject to direction and control by the agency with respect to the decisional outcome in any individual claim. ALJs are independent triers of fact who perform their evidentiary factfinding function free from agency influence. At the same time, the Administrative Procedure Act ensures that an ALJ's decision is subject to review by the agency, thus giving the agency full power over policy. Policy responsibility remains exclusively with the agency while the public has assurance that the facts are found by an official who is not subject to agency influence.

A hearing before an ALJ will remain an informal adjudicatory proceeding as it is under the current process. The claimant will have the right to be represented by an attorney or a non-attorney with the decision regarding representation made by the claimant alone. An informal, nonadversarial proceeding is consistent with the public's strong preference for a simple, accessible hearing process that permits, but does not require, an attorney. An informal process facilitates the earlier and faster resolution of the issues in dispute, thus promoting more timely decisions.

As an independent factfinder in a nonadversarial proceeding, the ALJ will still have a role in protecting both SSA interests and the claimant's interests, particularly when the claimant is unrepresented. However, an improved initial determination process with its focus on early and comprehensive evidentiary development, predenial

personal conferences, fully rationalized initial decisions, and prehearing analysis of contested issues should ensure that the Agency position is fully explored and presented to the ALJ. Moreover, the primary burden of compiling an evidentiary record will be shifted to the representative—if one is appointed—or to the claimant (when able to do so), with assistance (when appropriate), from SSA personnel.

Adjudication officers and other decision writers will assist ALJs in preparing hearing decisions, using the same decision support system that supports the preparation of initial disability determinations. A simplified disability decisional methodology, in conjunction with the use of prehearing stipulations that frame the issues in dispute, will result in shorter, more focused hearing decisions. If the ALJ issues a favorable decision, he or she will refer the claim back to the disability claim manager to effectuate payment.

The Administrative Law Judge Decision Will Be the Final Decision of the Secretary Subject to Judicial Review Unless the Appeals Council Reviews the Administrative Law Judge Decision On Its Own Motion

Under the new process, if a claimant is dissatisfied with the ALJ's decision, the claimant's next level of appeal will be to Federal district court. A claimant's request for Appeals Council review will no longer be a prerequisite to seeking judicial review.

As under the current process, the Appeals Council will continue to have a role in ensuring that claims subject to judicial review have properly prepared records and that the Federal courts only consider claims where appellate review is warranted. Accordingly, the Appeals Council, working with Agency counsel, will evaluate all claims in which a civil action has been filed and decide, within a fixed time limit whether it wishes to defend the ALJ's decision as the final decision of the Secretary. If the Appeals Council decides to review a claim on its own motion, it will seek voluntary remand from the court for the purpose of affirming, reversing or remanding the ALJ's decision. Favorable Appeals Council decisions will be returned to the disability claim manager to effectuate payment.

Additionally, the Appeals Council will have a role in a comprehensive quality assurance system. As part of this system which is described in greater detail below, the Appeals Council will also conduct its own motion reviews of ALJ decisions (both allowances and denials) prior to effectuation. If the Appeals Council decides to review a claim on its own motion, the Appeals Council may affirm, reverse or remand the ALJ's decision. The Appeals Council's review will be limited to the record that was before the ALJ.

Quality Assurance

Quality Assurance Will be a System of Agency Accountability

SSA will be accountable to the public, the ultimate judge of the quality of SSA service, and SSA will strive to consistently meet or exceed the public's expectations. SSA will have a comprehensive quality assurance program that defines its quality standards, continually communicates them to employees in a clear and consistent manner, and provides employees with the means to achieve them. SSA will devote resources to building quality into the system of adjudication to ensure that the right decision is made the first time. SSA will also systematically review the quality of the overall system of adjudication to ensure the integrity of the administrative process and promote uniform application of agencies policies nationally. Finally, SSA will measure customer satisfaction against the SSA standards for service.

Ensuring That the Right Decision is Made the First Time Requires an Investment in Employees

SSA's ability to ensure that the right decision is made the first time depends on a well-trained, competent, and highly motivated workforce that has the program tools and technological support to issue quality decisions.

SSA will make an investment in comprehensive employee training to ensure that employees have the necessary knowledge and skills to perform the duties of their positions. SSA will develop national training programs for initial job training and orientation as well as continuing education to maintain job knowledge and skills. Such training will include general communication skills and how to deal effectively with the public generally, and disability claimants in particular. National training programs will also address changes to program policy.

In addition to initial program training, continuing education opportunities will be made available to employees to enhance current performance or career development. These opportunities may be in the form of self-help instruction packages, videotapes, satellite broadcasts, or non-SSA training or educational opportunities. SSA will ensure that employees are given sufficient time and opportunity to complete the required continuing education. Employees will be encouraged to provide feedback on the value of these continuing education opportunities, including the quality of training materials, methods, and instructors.

Employees, other than ALJs (because of Administrative Procedure Act limitations), who complete initial training and pass a set of performance evaluations based on national quality standards will receive a certificate of competence. This certificate will attest that the employee has successfully completed both initial training and a probationary period on the job. Certification will be renewed yearly upon successfully completing required training and having no less than a fully satisfactory performance rating. Those employees not certified initially or renewed will be provided an improvement plan with goals and time targets for improved performance.

In addition to formal program training, SSA will rely on a streamlined and targeted system of in-line quality reviews and monitoring of adjudicative practices. The elements include a mentoring process for new employees and peer review for experienced employees. SSA will encourage peers to discuss difficult claims or issues and resolve them informally whenever possible. Peer reviews and mentoring will not only promote timely and accurate development of disability claims, but will also foster a spirit of teamwork. They will also promote earlier identification and resolution of problems with policy or procedures. As part of this process, managers will be expected to oversee the adjudication process. They will conduct spot checks at key points in the adjudication process or perform special reviews based on profiles of error-prone claims. The goal of these reviews is to provide immediate, constructive feedback on identified errors to reduce or eliminate their possible recurrence.

To ensure that adjudicators have the necessary program tools to issue accurate decisions, SSA will use a single mechanism for the presentation of all substantive policies used in determining eligibility for benefits. Additionally, an integrated claims processing system will provide the necessary technological support for adjudicators at all levels of the administrative process. Among other things, the claim processing system will facilitate the preparation of accurate decisions by providing on-line editing capacity to identify errors in advance

and decision support software to assist in analysis and decisionmaking.

Although comprehensive employee education and an in-line review system will build quality into the system of adjudication with the goal of error prevention, SSA must still monitor quality on a systematic, national basis. Accordingly, all employees will be subject to and receive continuous feedback from comprehensive end-of-line reviews as described in the following section.

Quality Measurement Will Focus on Comprehensive End-of-Line Reviews

Another component of quality assurance is an integrated system of national postadjudicative monitoring to ensure the integrity of the administrative process and to promote national uniformity in the adjudication of disability claims. This system will include comprehensive review of the whole adjudicatory process including both disability and nondisability issues, allowances and denials, and at all levels of decisionmaking. The review will focus on whether accurate decisions were made at the first possible step in the process. This type of review will not be aimed at correcting errors in individual claims but, rather, will be the means to oversee, monitor and provide feedback on the application of agency policies at all levels of decisionmaking. Reliance on an integrated claim processing system will facilitate the selection of a statistically valid sample of claims for this review.

SSA will use the results from these end-of-line reviews to identify areas for improvement in policies, processes or employee education and training. SSA will also use the results to profile error-prone claims with the goal of preventing errors at the front end.

SSA Will Conduct Surveys to Measure Customer Satisfaction

To measure whether SSA has met or exceeded the public's service expectations, SSA must measure their level of satisfaction with the level of service SSA provides. Customer surveys and periodic focus groups will be the most frequently used methods of determining the public's views on the quality of SSA service. SSA will also survey representatives and third parties who provide assistance or act on claimants' behalf in dealing with SSA. Survey results will be communicated to staff on a timely basis, both as Agency feedback and individual feedback, along with any plans to address identified problems.

SSA will also seek employee feedback on how well SSA has met their expectations. Employee feedback will be sought on a wide array of issues including Agency goals and performance indicators, training and mentoring needs, and the quality of operating instructions. Although formal mechanisms will be used to obtain feedback periodically, each employee will be encouraged to provide continuous feedback on how to make improvements in the process.

Measurements

SSA Will Measure Disability Service From the Perspective of the Claimant

SSA's management information will be revised to assess the performance of the Agency as a whole in providing service to claimants for disability benefits. Management information regarding the contributions at each step in the process to the final product, as well as to the work product passed on to other steps will be available. For example, current component processing time measures will be replaced by a measure of time from the first point of contact with SSA until final claimant notification. Meaningful, timely management information will be facilitated by a seamless claim processing system with a common database that is used by all individuals who contribute to each step in the process.

Other measures, such as cost, productivity, pending workload, and accuracy will be developed or revised to assess the performance of the Agency as a whole and the participants in the process who contribute to this performance. Measurements for public awareness, as well as claimant and employee satisfaction will add to this assessment.

New Process Enablers

Reengineering is dependent upon a number of key factors that provide the framework for the new process design. Each of these enablers" is an essential element in the new disability determination process.

Process Unification

Under the Social Security Act, the Secretary has been granted broad authority to promulgate regulations to govern the disability determination process. In addition to the regulations, SSA publishes Social Security Rulings and Acquiescence Rulings. Social Security Rulings are precedential court decisions, policy statements, and policy interpretations that SSA has adopted as binding policy. Acquiescence Rulings explain how a decision by a U.S. Court of Appeals will be applied when the court's holding is at variance with the Agency's interpretation of a provision of the statute or regulations.

These source documents provide the basic framework for the policies that regulate eligibility for benefits. Administrative law judges (ALJ) and the Appeals Council use these source documents in making disability decisions. However, they are not directly used by decisionmakers at the first two levels of the process, i.e., initial and reconsideration determinations. Guidance for these decisionmakers is provided in a series of administrative publications specifically designed for and aimed at the audiences responsible for adjudicating these claims.

The Program Operations Manual System instructions provide the substance of law, regulations, and rulings for adjudication issues in a structure format that does not necessarily repeat the wording of the source documents for field offices, State disability determination services (DDS), the processing centers, and quality assurance reviewers. The Program Operations Manual System is supplemented by other administrative issuances to clarify or elaborate specific policy issues. The Program Operations Manual System also provides basic operating instructions to the initial, reconsideration and quality components responsible for processing claims. The Hearings, Appeals, and Litigation Law Manual provides operating instructions and summaries of court decisions to hearing offices and the Appeals Council.

Neither the Program Operations Manual System or the Hearings, Appeals, and Litigation Law Manual is binding on ALJ decisionmaking because this material is not considered Agency policy under the Administrative Procedures Act. Only those regulations and interpretative rulings published in the **Federal Register**, in accordance with the Administrative Procedures Act guidelines, can be binding on ALJs. Other decisionmakers are bound by interpretative guidance in the Program Operations Manual System and supplemental issuances. This situation fosters the perception that different policy standards are used at different levels of decisionmaking in the claims process.

SSA will develop a single presentation of all substantive policies used in the determination of eligibility for benefits. All decisionmakers will be bound by these same policies. These policies will be published in accordance with the Administrative Procedures Act. In addition, to facilitate the flow of work in the new process, a single operating manual will be developed.

Public and Professional Education

Public and professional education is essential for the proper understanding of and participation in the disability claims process. The goal is to ensure that those individuals and groups involved in the disability process have a better understanding of SSA disability programs, their medical and nonmedical requirements, and the nature of the decisionmaking process.

SSA will make information widely available for the general population. Pamphlets, factsheets, posters, videos, information on diskettes and on computer bulletin board systems will be developed. This information will be written in a simple, straight forward and understandable manner. It will be available in many languages and dialects and will accommodate vision and hearing impaired individuals. Videotapes will be available to show in SSA offices, welfare offices and in places where medical care is provided. It will explain the definition of disability, stressing the durational and level-of-severity requirements while giving real life examples. Insured status requirements for SSA disability insurance (DI) and income and resource limitations for supplemental security income (SSI) will be explained in general terms.

This same information will be distributed to third parties who may be referral sources for disability claims. It will serve to provide them with basic information about medical and nonmedical eligibility criteria and the options available for filing claims.

SSA will work with nationally and locally interested and involved groups to develop direct lines of communications about the disability process and program. These efforts will not be limited to providing information, but will include opening and maintaining a dialogue about the disability process as part of an ongoing organizational relationship.

Professionals who work with the disabled population will require more detail. The current "Understanding SSI" booklet will be enhanced to include more information on the disability aspects of the SSI program—including the requirements and process, as well as the options available to claimants or interested third parties to speed up the process. A similar booklet for the DI program will be developed. These booklets will serve as training manuals and reference tools, and will include information and examples about providing functional assessments. Special efforts will be made to have coverage of these booklets included in courses which are part of a social service delivery curriculum at the post-secondary and graduate levels.

SSA will conduct outreach efforts with the legal community, to ensure that information about the disability programs is widely available to the organized bar and the Federal judiciary. Policy documents, regularly updated electronically, and rules of representation will be available at forums sponsored by the organized bar and in initial orientation and continuing legal education programs designed for Federal judges.

Treating physicians, medical providers and other treating professionals need up-to-date information on medical evidence requirements. SSA will conduct educational outreach with the medical community to provide them with a better understanding of the SSA disability programs, the medical and functional requirements for eligibility, and the best ways to provide medical information needed for decisionmaking. In addition to the use of printed materials, SSA will arrange briefings and training sessions in association with medical organizations and societies at the local, State and national levels, as well as through hospital staff meetings.

Those medical providers who conduct consultative examinations for SSA will need ongoing training regarding changes in the disability program. SSA will prepare training programs for this audience which will utilize written, audiotape, videotape, and computerized training methods.

Claimant Partnership

As part of their partnership with SSA, claimants will be encouraged to actively participate at all levels of the adjudication process and will be fully informed of their rights and responsibilities. SSA's interaction with claimants will facilitate claimant responsibility and active participation in the processing of their claims. The resources of interested and capable third parties will be garnered to assist claimants and SSA in fulfilling their partnership responsibilities.

The majority of claimants are able to complete simple forms, attend appointments, and obtain medical and nonmedical documentation, either on their own or with the assistance of third parties. Other claimants are unable to accomplish some of these tasks, even with the assistance of third parties. Still others have substantial difficulty fulfilling any of these tasks, and may have no third party to assist them. Given the range of claimant capabilities, SSA will retain ultimate responsibility for development of claims when claimants are not formally represented.

What SSA Will Do

SSA's interaction with claimants will focus on enabling their participation in the process. Understandable public information materials and application packets will be widely available. Explanations of the program, the process, and claimant responsibilities will be furnished at the point individuals first make contact with SSA. SSA will also work with third parties, such as family members and community-based organizations, to provide additional claimant support.

In addition, SSA will provide ongoing assistance and appropriate status information throughout the process. The opportunity for personal contact with the disability claim manager will be afforded to each claimant prior to the issuance of an initially unfavorable decision. A claimant will be advised of evidence that has been considered in making the disability determination and provided an opportunity to present additional evidence for consideration.

Claimants will be provided the opportunity to fully participate in the appeals process. Decision rationales, appeal rights, and representation rights will be explained in clear, understandable language.

What Claimants Will Do

Early, ongoing dialogue between claimants and SSA will ensure that claimants have access to information and resources they need to actively pursue their claims and make informed choices.

Claimants will be asked to do more to facilitate development of supporting information when they are able, particularly with respect to medical evidence. When they file for disability benefits, claimants having had medical treatment will be asked to request that their treating sources complete standardized forms. Information about this requirement will be publicized in the general community and given to claimants and third parties when they first contact SSA. Third parties will be encouraged to assist claimants who are unable to fulfill this obligation on their own. However, when necessary, a disability claim manager will assist claimants in obtaining evidence.

To encourage the release of evidence by treating medical sources, SSA will network with the treating source community to overcome the lack of understanding and possible resistance to providing patient information. SSA will develop fax, E-mail, and other

electronic means for physicians to provide direct certification information.

There will be situations where claimants have no treating sources, or where treating sources provide insufficient medical evidence to make a disability determination. SSA will work with willing treating sources and other medical providers to assist in developing medical evidence (including testing and examination) in these circumstances.

SSA will encourage private insurers and public agencies that refer claimants to SSA as a condition of receiving other benefits to provide medical evidence for these individuals.

Claimants will be able to fully participate in the appeals process with or without a representative. During the appeal process, claimants and/or their representatives will have primary responsibility for compiling an evidentiary record. SSA will provide appropriate assistance for unrepresented claimants.

Assistance to Claimants

Many claimants today rely on other individuals; private and public organizations; and for-profit and nonprofit organizations to pursue their claims. Although they assist claimants, these individuals and organizations do not serve as official representatives. In most instances, those who assist in the process have the best interests of the claimant in mind. However, some individuals and organizations have been instrumental in attempts to defraud programs or take unfair advantage of claimants. In the future, SSA will develop ongoing relationships with community organizations to ensure that competent third-party resources are available to assist the claimants.

Examples of resources that SSA will help develop include:

—Transportation and escort services for indigent claimants and those who experience difficulty in getting to consultative examinations. This would include a combination of volunteer services and reimbursement for transportation on a contract basis. These services will be immediately available as the need dictates.

—Enhancement of medical provider capacity to identify potentially eligible patients, secure claims and provide medical evidence. This type of activity has been successfully demonstrated through the use of seed monies from SSA in the SSI outreach program. An additional financial benefit to the providers will be realized through concurrent Medicaid eligibility for patients.

—Software with compatible format design which will allow direct input of claims-related information to SSA. This will be available to claimant advocates and medical providers ensuring the rapid and accurate transmission of information. After a certification process, eligible users will be kept apprised of software, procedural, and policy changes. SSA will perform ongoing document verification to ensure the integrity of claims submitted by such users.

SSA will have an ongoing demonstration program that provides funds for truly innovative projects that test models for national implementation.

In order to expedite the referral of potentially eligible individuals, SSA will develop productive working relationships with Federal, State and local programs that serve individuals with disabilities. While eligibility requirements vary significantly for programs such as Food Stamps, Aid to Families with Dependent Children, General Assistance, foster care and adoption assistance, and Veterans Benefits, effective working relationships can be built around agreements that expand sharing of authorized information and awareness of program requirements.

Other programs will be able to use SSA-developed decisional support systems to evaluate potentially eligible persons prior to referral. This information will be transferred to SSA through compatible databases. To further enhance these relationships, disability claim managers will be available in remote locations, such as Department of Veterans Affairs homeless program sites, where the workload warrants their presence. With appropriate information available at these sites, the on-site disability claim manager will be able to complete the entire initial application process, with access to other program experts through information systems. Local managers will be encouraged to develop and maintain appropriate working relationships with local Federal, State and third-party resources.

The Payoff Will be Greater Customer Satisfaction

Active participation by claimants, supported by SSA's efforts and the contributions of third parties will result in a fundamental shift in claimant expectations and satisfaction with the SSA disability process. From the SSA perspective, the results will be better service to customers through timely, fully supported decisions rendered at all decisional levels; better use of SSA resources focused on helping those who need assistance; and greater public confidence in the disability adjudication process.

Workforce Maximization

Teamwork

The teamwork concept is a fundamental ingredient in the new process. The disability claim manager will be the focal point at the initial claim level, assisted by technical and medical support staff. The adjudication officer will be the focal point at the prehearing level, relying on technical and medical support staff, as well as interacting with the disability claim manager and the administrative law judge (ALJ), as necessary. The ALJ will be the focal point at the hearing level, receiving support from technical and medical support staff, and also interacting with the adjudication officer and disability claim manager, as necessary.

Each team member will have at least a basic familiarity with all the steps in the process and an understanding of how he/she complements another's efforts. Everyone will achieve a greater sense of participation, closure, and accomplishment because of shared responsibility for performing the whole process. Team members will maintain ownership of the process and the outcomes. The teams will function effectively and efficiently because:

—All members will have electronic access to the claim throughout the process and thus be better able to engage in meaningful discussions with the claimant.

—Handoffs, rework, and non-value steps will be significantly reduced and fewer employees will be involved in shepherding each claim through the process. This will enhance SSA's capacity to provide world-class service by allowing employees to devote more time to each claimant, providing more personalized service.

—Team members will be knowledgeable but will also be able to draw upon each other's expertise on complex issues.

—Improved automated systems will enable members of the team to work together using a shared data base even when they are not co-located.

—Communication between team members and other disability claim managers will encourage consistent application of disability policy.

—Customer service is the primary focus at all steps of the process and an integral part of the teams' goals. This focus and commitment will increase claimant satisfaction.

—Team members will work closely with social service and medical/professional agencies and advocacy groups in the service area to improve their ability to obtain the necessary medical and functional information to appropriately evaluate disabling conditions.
—Varying levels of job complexity will provide the opportunity for personal development, growth, and learning.

Disability Claim Managers

Disability claim managers will be responsible for intake of DI and SSI disability/blindness benefit claims, development of all evidence (medical and nonmedical) required to adjudicate those claims, final adjudication of claims, ongoing communication with claimants, and issuance of notices and/or payment actions. In carrying out these responsibilities, disability claim managers will work in a team environment with medical and nonmedical experts who provide advice and assistance with complex case adjudication, as well as support personnel who handle more routine aspects of case development and payment effectuation. Tasks will be facilitated by a fully automated intake process, developmental and decisional expert system applications, personalized automated notices, and automated payment computations.

Disability claim managers will be able to:

—Provide claimants with current and accurate information about their claims;
—Anticipate documentation needs and eliminate development that is not necessary in favorable determinations;
—Eliminate time lost and rework caused by frequent handoffs and queues;
—Access expert advice through shared databases, thus eliminating the need to transfer files;
—Provide claimants with complete information if their claims are proposed for denial and enhance claimants' ability to rebut such outcomes easily and early in the process; and
—Effectuate payment quickly, thus avoiding the need for recontacts and verification of nondisability factors of eligibility.

Adjudication Officers

Adjudication officers will be responsible for claims from the point of receiving hearing requests until they are ready to be heard by ALJs. In carrying out their responsibilities, adjudication officers will work in a team environment with medical and nonmedical experts, requesting advice and counsel from ALJs as necessary.

Adjudication officers will be able to:

—Address the claimants' questions and concerns regarding their claims;
—Identify and discuss issues in dispute with claimants and determine the need for additional evidence. If the claimant is represented, conduct personal conferences with the representative and prepare written stipulations as to those issues not in dispute;
—Review claim records prior to hearings and issue revised decisions if additional information or evidence so warrants or refer claims for medical consultation; and
—Take responsibility for all evidentiary development and refer prepared records to the ALJs.

Administrative Law Judges

Administrative law judges (ALJ) will be responsible for hearing and deciding appeals. ALJs will receive support from technical and medical personnel, including decision writers. ALJs will also work with adjudication officers and disability claim managers as necessary.

ALJs will be able to:

—Review and focus on fully developed claims records prior to hearings;
—Deal with claimants who have already made informed decisions regarding representation before they appear at hearings; and
—In most circumstances, close the record at the conclusion of hearings, deliberate on issues and render prompt decisions.

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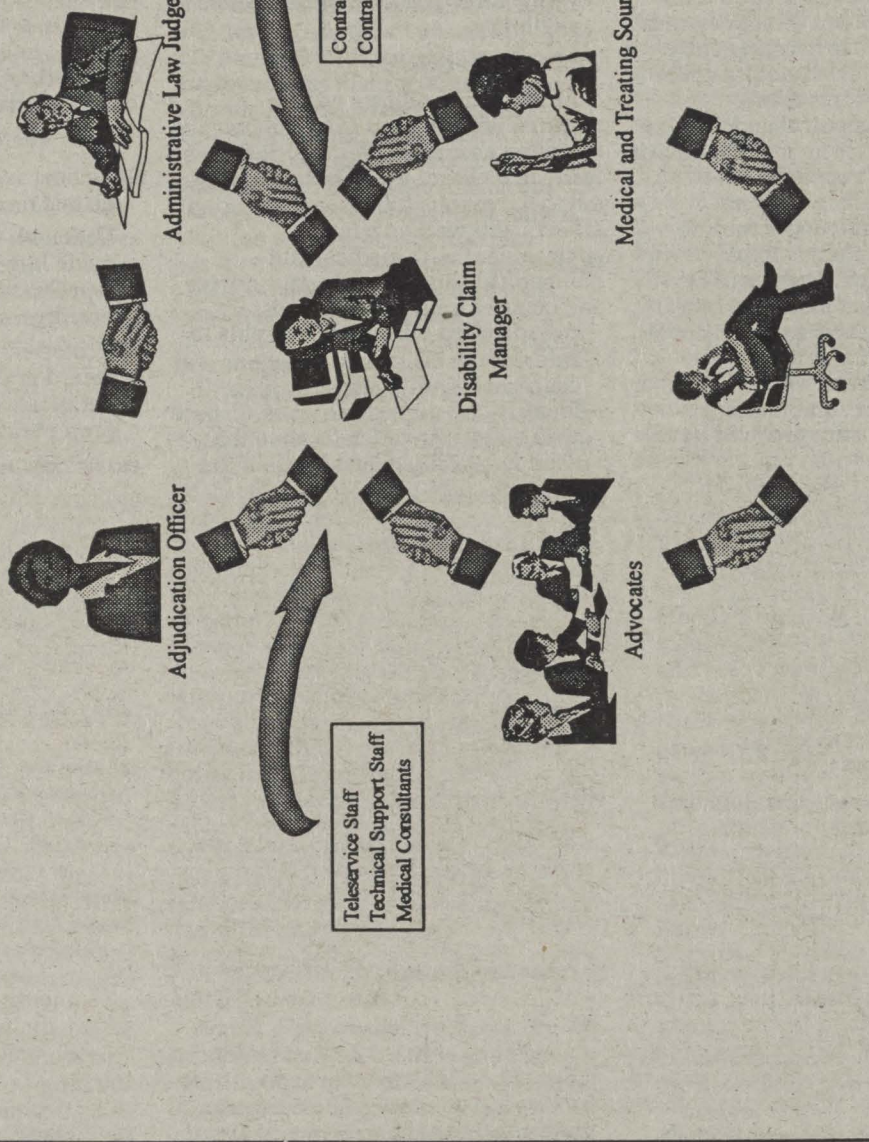
Figure 16

Dynamics of the New Process



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Workforce Enrichment/Empowerment

The work in the new process will raise job satisfaction and increase employee skills in the following way:

Employees involved with the initial level of claims will perform multiple tasks instead of singular activities, thus their roles will expand to encompass more of the "whole" job. This increases the sense of accomplishment as employees experience the direct relationship between their actions and the final product. Those at the prehearing step will also be able to do more of the "whole" job, including taking action to allow claims much earlier in the process. For medical consultants and ALJs, tasks will be eliminated that are not commensurate with professional skill levels. Employees will feel more of a sense of ownership for the services they perform as a member of a team focused on serving claimants.

Entry level positions will be developed in which employees work as part of the team while gaining experience and qualifying for greater responsibility. Adequate resources and sufficient training and mentoring will allow them to acquire the skills they need to process the claim from intake through adjudication rather than guessing what someone else needs or using the current all-encompassing approach to information gathering.

The new process will rely heavily on increased employee empowerment applying information technology and professional judgment to complete tasks more effectively and efficiently without constant checking, direction and micro-management. Recognition and reward processes will be revised to emphasize contributions to team outcomes and acquisition of knowledge bases. Continuous quality improvement activities will foster ongoing incremental process change.

Representatives: Fees, New Rules and Standards of Conduct

The Social Security Act and implementing regulations have long recognized the representational rights of claimants and have provided an administrative framework designed to ensure that claimants will have access to the legal community in the pursuit of their claims. Since the inception of the disability program, representatives have played a significant role in the disability process. The rate of representation in SSA disability claims has risen from approximately 55% in fiscal year (FY) 1982 to 75% in FY 1993. Focus groups of claimants and the general public have indicated that the disability program is too complex to understand and the process too fragmented and difficult for them to navigate alone. While many claimants resent having to pay a representative to establish entitlement to government-sponsored benefits, they feel that they have no choice if they want to be successful in this pursuit. While the rate of representation has risen, so too has the average fee for representation. The average fee received by representatives has jumped from approximately $1,500 in FY 1987 to $2,500 in FY 1993, further adding to the dismay of claimants. As more claimants seek representation and fees continue to climb, SSA has a heightened responsibility to monitor representational activity and to safeguard the interests of claimants. The proposed process will utilize new rules of representation and standards of conduct to ensure that representatives, as key players in the disability process, fulfill their responsibilities and adequately serve the needs of the claimants they represent.

Under the present statutory and regulatory scheme, representatives are not permitted to charge and collect a fee in any case without first obtaining the approval of the Secretary. There are two distinct procedures available to representatives for obtaining fee approval. The "fee petition" method requires the representative to itemize the services rendered and the time expended. The Secretary must evaluate each individual petition and determine the reasonable fee, considering such factors as case complexity, time expended, skills needed, and the results obtained. There is *no maximum fee* set by law for this procedure.

The second method, commonly referred to as the "fee agreement procedure", involves an agreement between the claimant and the representative whereby the fee is agreed to be no more than 25% of the retroactive benefits due, or $4,000, whichever is less. The agreement must be executed and submitted to the Secretary prior to the determination of the claim. While there is a maximum fee under this procedure, the Secretary does not have to conduct an individual evaluation of the reasonableness of the fee unless either the claimant, the representative, or the administrative law judge (ALJ) files a protest of the fee. The fee may be reduced by the Secretary *only* on the basis of evidence of the failure of the representative to adequately represent the interests of the claimant or on the basis of evidence that the fee is clearly excessive for the services rendered. Under limited circumstances, the representative may ask the Secretary to increase the fee.

In addition to approving all fees under both DI and SSI of the Social Security Act, there are withholding and direct payment of fee provisions that apply only to DI claims where an attorney is involved. Specifically, the Secretary must withhold and pay to the attorney the lesser of (1) 25% of the retroactive benefits due the claimant, or (2) the fee approved by the Secretary under either the fee petition or fee agreement procedures. The intent of this procedure is to provide an incentive for attorneys to accept Social Security claims work in order to increase claimant access to attorneys. In FY 1993, SSA paid nearly $300 million in fees to attorneys out of claimants' retroactive DI benefits. This withholding and payment provision does not apply to SSI claims because Congress did not find it appropriate to reduce a claimant's benefits in order to pay an attorney in a means-test program. However, even though SSA does not withhold and pay attorneys fees in these cases, it is estimated that SSI claimants paid over $133 million in fees to their representatives in FY 1992. Thus, the total cost to claimants for representation in 1993 approached the $500 million mark.

Since the inception of the fee agreement procedure in 1991, fee agreements have been rapidly replacing fee petitions as the vehicle for procuring agency approval of fees. SSA received 52,297 fee agreements in FY 1992, representing 39% of all fee approval requests. In FY 1993, fee agreements jumped to 87,395, accounting for 63% of all fee approval requests. Fees are generally higher under the fee agreement procedure, averaging $2,800 in FY 1993 as compared to an average fee of $2,200 for fee petitions. One of the factors causing higher fees under the fee agreement procedure is the lengthy processing time for disability claims; the longer it takes to issue a decision, the greater the retroactive benefits due the claimant. Under the fee agreement procedure, the fee is based on the amount of retroactive benefits due, and there may be little or no correlation to the time expended by the representative or the skills involved in rendering representational services. By eliminating fragmentation and handoffs, the proposed process will significantly reduce processing time. SSA will issue decisions faster, the amount of resulting retroactive benefits will be reduced, and resulting fees will likewise be reduced.

However, as the fee agreement procedure continues to claim an ever-increasing share of the total number of

fee requests filed each year, more and more fees will be based upon a predetermined, mathematical formula rather than by an independent evaluation of the quality of services rendered. In order to maintain the emphasis on quality in representational matters, the proposed process will adopt new representation rules and standards of conduct to effectively safeguard the rights and interests of claimants. These new regulations will:

—Establish qualifications for representatives, attorneys and non-attorneys, to ensure that claimants receive competent representation;
—Define the duties and responsibilities of representatives, including the duty to fully develop the record in a timely manner and to respond to requests to submit evidence;
—Establish a code of professional conduct for representatives in all matters before SSA, including conduct at prehearing conferences, hearings, and interaction with SSA employees and claimants generally;
—Provide a forum for claimants to air their grievances and file charges against representatives for failure to provide adequate representation or otherwise violating the rules of representation and standards of conduct;
—Provide meaningful sanctions against representatives, including suspension and disqualification from appearing before the agency in a representative capacity, for violating any of the provisions contained in the rules of representation and standards of conduct.

Without disturbing the statutory intent of facilitating claimant access to representatives, the simplified and user-friendly new process may well result in more claimants pursuing their claims without representation. However, the issue of representation will remain a matter of personal choice. In addition, the proposed process will reduce the trend of inflationary fees by eliminating the artificially high retroactive benefits that result from excessively long processing times. Finally, while current statutes and regulations attempt to protect claimants from fee abuses, they fall short of extending to claimants the assurances which they need most: that the representatives they retain will be qualified, will have the obligation to fully develop the record on their behalf, will adequately represent their interests, and will be accountable for misconduct or dereliction of duty. The new rules and standards of conduct provide the framework for these assurances.

Information Technology

Information technology will be a vital element in the redesign of the disability claim process. To the fullest extent possible, SSA will take advantage of the "Information Highway" and those technological advances that can improve the disability process and help provide world-class service. Existing Agency design plans for Intelligent Workstation/Local Area Network (IWS/LAN) and a Modernized Disability System are critical enablers for successful implementation of the proposed process redesign. Reengineering of the disability process is on the critical path of the design and development of the Modernized Disability System and implementation of IWS/LAN.

The Modernized Disability System and IWS/LAN will provide an integrated system to support the entire reengineered disability process. This system will provide electronic connectivity throughout the process. Current SSA systems that support disability processing operate independently of each other. Field offices, DDSs and hearing offices all have their own systems. The DDSs have their own baseline automation systems, but for the most part can only use the systems within the particular State on that State's machines. Likewise, hearing offices have a disability processing system that applies only to claim processing inside the hearings and appeals organization. Each organization independently inputs claim information into their systems and no *automated* information can be passed outside the organization for subsequent, much less parallel, claim processing.

The reengineered process relies on the ability to build a single electronic claim record as it goes from point to point in the disability process. This includes the ability for any facility to process the medical and nonmedical segments of claims for another facility. This is the primary benefit of the IWS/LAN and Modernized Disability System architectures. Both architectures are a prerequisite for enabling reengineering of the entire disability process.

The Enabling Platform

The IWS/LAN architecture and Modernized Disability System design will support a major objective of the redesigned disability process-seamless, reengineered electronic processing of disability claims from the first contact with the claimant to the final decision, including all levels of administrative appeal. All employees will use the same hardware, the same claim assignment and scheduling software, the same claim processing software, the same case control system, the same fiscal and accounting software, the same integrated quality assurance functionality, and the same management information system throughout all stages of the process. Therefore, data will need to be input and validated one time only, leading to more consistent decisions in establishing both the medical and nonmedical aspects of DI and SSI claims. All employees will also have access to decision support systems for those complex entitlement decisions. Since all facilities will be able to access the same record, all SSA representatives will be able to respond to inquiries from the same base of information. This will produce more consistent and accurate Agency responses to inquiries.

SSA will continue to move aggressively toward the goal for complete electronic, paperless processing with all aspects of the claims process. Key tenants of reengineered electronic, paperless processing will be encouraging electronic information exchanges with medical evidence providers—and then keeping information received electronically in that same (or a similar) digitized format for claim processing, use of cost effective scanning/imaging of decision supporting paper records, abstraction and/or summarization of key, paper-based information by employees via direct keying, and finally, direct keying of information into the claim processing system by employees, third parties, and/or claimants. Direct keying of information into the electronic file will be minimized whenever possible by reliance on data propagation from other SSA files and comprehensive database support throughout the claims processing systems.

Although full realization of a completely automated system will be a long-term initiative, a number of aspects of the redesigned process will be quickly realized and made possible by IWS/LAN and Modernized Disability System support in the very near future.

Redesign of Access to Services

Information technology will be applied in several ways to enhance the claimants' and representatives' access to services and information under the new process. Through reengineering, claimants will be able to conduct business with SSA via telephone, self-help workstations, kiosks, videoconferencing, and electronic data transfer at SSA facilities and other satellite locations. SSA will provide TV/VCRs and/or kiosks in SSA facilities and public places where there is a high

concentration of potential customers to dispense information about SSA programs, the requirements for eligibility, and the information requirements for filing an application. The better informed the customers, the better prepared they are at the time of the interview. This reduces recontacts and allows the customer to more fully participate in the timely pursuit of their claim.

Waiting rooms will be equipped with self-help workstations housed in private cubicles. They will help to pre-screen program eligibility and furnish application requirement information for walk-in claimants. These workstations can also be used as front-end interviewing devices that collect preliminary application information from claimants. The preliminary information will be used to access SSA databases to gather all known information on the claimant, including earnings history and any prior filings.

Application information will include the telephone numbers from which claimants or representatives will make telephone inquiries. SSA office telephone systems will be equipped with automatic number identification technology (also known as "caller ID"). Using this technology, SSA will be able to provide improved service by responding to telephone inquiries with increased assurance that the caller is the claimant or representative.

Customer Self-Help Redesign

An efficient paper application form designed to be easily read and indexed by scanning equipment will be widely available as part of a comprehensive consumer information publication about the disability program that will be stocked in SSA facilities and other appropriate community-based locales. Self-help instructional material will also be mailed to some applicants who inquire about disability benefits by calling SSA. Up-front completion of the form will not be a requirement of filing, but will enhance the intake process for applicants. The Modernized Disability System will have the capability to accept scanned information from the application form and integrate all relevant information into the electronic file.

In addition, an electronic application form will be made available to claimants with access to a personal computer and modem using an SSA bulletin board service or through other publicly available bulletin board services. The information will be completed and returned electronically to SSA via an agreed upon electronic filing method.

Finally, as previously mentioned, some claimants will begin the application process by completing a brief electronic application form using SSA self-help workstations in SSA offices and other community-based locations.

Enhanced Third Party Support

SSA will conduct forums and produce video and computer-based training materials for third parties who wish to participate in assisting customers to file applications and gather medical evidence. Wherever possible, physicians and health care organizations, advocates, community counseling services, and other professionals who regularly provide assistance to SSA claimants will be supplied with SSA software to electronically complete Agency forms. The data will be transferred to SSA using agreed upon methods. As long as these parties comply with certain stipulations, SSA will supply updates to software and procedures, and/or establish an SSA bulletin board from which these third parties can download current software.

SSA will allow representatives access to electronic claim folders. This access will be limited to the authorized representative (attorney or non-attorney) of the claimant and will be allowed from self-help workstations at an SSA facility, or via an agreed upon electronic data transfer method.

Evidence Collection Redesign

Medical Evidence of Record is to the disability process what the earnings record is to the Retirement and Survivors' Insurance program. SSA will marshall its resources for an "Evidence Modernization Project" as was successfully done for the Earnings Modernization Project. The success of Earnings Modernization was due, in no small part, to the partnership SSA established with the employer community to streamline and focus the wage reporting requirements. The redesigned disability process approach provides for similar partnership with medical providers and the necessary streamlining of evidence collection requirements.

SSA will expand its acceptance of interpretive data from the medical community. Instead of relying solely on actual medical records, SSA will focus on obtaining certifications of the diagnostic and functional information needed to make disability determinations. These standardized certifications will be designed to solicit from the treating source the specific information needed and enable SSA to process the information in a timely and accurate manner.

Electronic standardized treating source information will be transmitted from physicians to SSA and associated with the appropriate electronic record. If additional medical evidence is needed and it is not already electronic, it will be scanned and stored digitally, or it may be abstracted and stored electronically. "Fax ID" and "caller ID" will be established with all parties submitting evidence or who have rights to legitimately request evidence. As was done during Earnings Modernization with the employer community, SSA will take advantage of the expanding use of computer applications by medical providers by working with software vendors that currently service the medical community to include an application for treating source reporting in office automation software.

The paper version of the standardized treating source form will be designed so that the data can be read by scanning equipment into SSA claims processing systems. The form will be designed to support the structure of the Modernized Disability System.

A single vendor payment system utilized by all appropriate employees will be used to pay certain evidence providers for information which they provide SSA to aid in making a disability determination. To further paperless processing, SSA will adopt a "signature on file" policy for the claimant's evidence release authorization to eliminate routing of paper medical release forms.

SSA will also set up information exchanges with other Federal and State agencies and major medical providers using pin/password access to data stores as well as caller/fax ID to conduct information exchange over the telephone.

Reengineered Tools For Decisionmakers

The ability of decisionmakers to conduct thorough interviews and evidence evaluation, and timely and accurate claims adjudication is predicated on the implementation of the functionality provided by the IWS/LAN hardware and software components, and the decision support features of the Modernized Disability System. The IWS/LAN environment provides access from the decisionmakers' desktop to electronic policy and procedures, multiple/simultaneous information processing and retrieval sessions with SSA claims processing systems, simultaneous access to both intelligent workstation-based office automation software and SSA claims processing systems, and access to modern

information-handling and transfer technologies such as fax. With all of the tools at the decisionmakers' fingertips, time is not wasted in logging on and off claim processing systems to get to other claim processing systems or office automation applications, nor is time lost by having to log off the system in order to leave the workstation to research manual reference materials.

Expert system software will be included in SSA claims processing systems to assist disability decisionmakers in the analysis and evaluation of complex eligibility factors, and to ensure that the correct procedures for disability evaluation are followed. While conducting interviews, disability decisionmakers will use the decision support features of the Modernized Disability System which ask specific questions based on claimants' alleged impairments.

This will provide more personalized service for claimants since the decision support questions will be tailored to their particular impairments. The decision support system will use the accumulated data of the electronic record to automatically produce "statement of the claim" summaries and decision rationales used throughout the determination process.

Where disability decision team members cannot be physically co-located, they can remain in communication by using two-way TV and other videoconferencing technologies. Handoffs, and the queues associated with each handoff, can also be minimized by the use of expert systems because much of the specialized knowledge that a task requires will be electronically stored in the knowledgebase of the expert system and immediately available. Therefore, the number of situations where employees will have to handoff claims to other employees having more technical expertise will be reduced.

Expert systems will also be developed to improve the delivery of disability policy. Disability policy will be developed and stored in a format that can be integrated into computer systems as the source of context-sensitive help screens and decision-support messages. SSA components responsible for disability policy will be responsible for updating the system with policy language revisions that do not require programming changes.

Quality Assurance and Management Information Redesign

Quality assurance features fully supported by the Modernized Disability System will be integrated throughout the new process. For example, the national end-of-line quality review sample will be electronically selected and automatically routed to appropriate staff. In-line programmatic quality assurance, enhanced by the use of decision support systems, will be programmed into the computer applications and will help to identify errors of both oversight and substance, and also support routine analysis to aid in avoiding future similar errors. An on-line technical review will occur each time information is added to the electronic record.

Quality assurance and productivity measures will be incorporated in a new, total-process management information system. Meaningful, timely management information for the disability process is dependent on a seamless data processing system used by all components which affords a common case control system and a common data base. SSA's claim processing systems integrated on an Agency-wide IWS/LAN platform will provide this seamless environment.

The Modernized Disability System management information design supports the new process goal of providing access from a desktop computer to total-process management information data no more than 24 hours old. In addition to the routine, published national reports generated from the management information system, other reports needed by national or local entities, or individual employees will be preformatted and system-generated on demand. Managers and empowered employees will have the flexibility to change parameters and to access the full data base, permitting comparison of peer performance and trend analysis. The system would also permit custom, ad hoc reports for special studies or immediate special purpose activities with access to the full data base. Tools including user-friendly report generator software and statistical forecasting and modeling applications will be available on the intelligent workstation to assist users in the data analysis.

Appendix I—Reengineering Design Partners

Director, SSA Process Reengineering Program

Rhoda Davis—Office of the Commissioner, Baltimore, MD.

Disability Process Reengineering Team

William Anderson—Office of Disability, Baltimore, MD.

Mary Ann Bennett—Office of Budget, Baltimore, MD.

Bryant Chase—Office of the Deputy Commissioner for Systems, Baltimore, MD.

Kayla Clark—Office of Hearings and Appeals, Seattle, WA.

Judith Cohen—Office of Supplemental Security Income, Baltimore, MD.

Judge Alfred Costanzo, Jr.—Office of Hearings and Appeals, Pittsburgh, PA.

Kelly Croft—Office of Workforce Analysis, Baltimore, MD.

Mary Fischer Doyle—Office of Hearings and Appeals, Falls Church, VA.

Virginia Lighthizer—Chicago Region, Detroit Conner Branch Office, Detroit, MI.

Rebecca Manship—Disability Determination Service, Sacramento, CA.

Mary Meiss—Office of Hearings and Appeals, Philadelphia, PA.

Michael Moynihan—Office of Disability and International Operations, Baltimore, MD.

Donna Mukogawa—Office of the Regional Commissioner, Chicago, IL.

William Newton, Jr.—Office of Disability and International Operations, Baltimore, MD.

Ralph Perez—Atlanta Region, Miami South District Office, Miami, FL.

Dr. Nancie Schweikert—Disability Determination Section, Nashville, TN.

Ronald Sribnik—Office of Regulations, Baltimore, MD.

Sharon Withers—Philadelphia Region, Welch District Office, Welch, WV.

Special Thanks to

Linda Kaboolian—Kennedy School of Government, Harvard University, Cambridge, MA.

Miriam Kahn—Process Reengineering Staff, Baltimore, MD.

Kenneth Nibali—Process Reengineering Staff, Baltimore, MD.

Leonard Ross—Office of Workforce Analysis, Baltimore, MD.

John Shaddix—Office of Telecommunications, Baltimore, MD.

Sandi Sweeney—Process Reengineering Staff, Baltimore, MD.

Latesha Taylor—Process Reengineering Staff, Baltimore, MD.

Process Reengineering Program Executive Steering Committee

Shirley Chater—Commissioner, SSA.

Lawrence Thompson—Principal Deputy Commissioner, SSA.

Rhoda Davis—Director, Process Reengineering Program, SSA.

Dennis Brown—Moderator, Association of OHA Analysts.

Bruce Bucklinger—President, OHA Managers' Association.

Robert Burgess—President, National Association of Disability Examiners.

Mary Chatel—President, National Council of Social Security Management Associations, Inc.

Herbert Collender—President, SSA/AFGE National Council of Payment Center Locals (Council 109).
Renato DiPentima—Deputy Commissioner for Systems, SSA.
John Dyer—Deputy Commissioner for Finance, Assessment and Management, SSA.
Richard Eisinger—Senior Executive Officer, SSA.
George Failla—Director, Office of Information Resources Management, SSA.
Gilbert Fisher—Assistant Deputy Commissioner for Programs, SSA.
Howard Foard—Assistant Deputy Commissioner for Policy and External Affairs, SSA.
Hilton Friend—Acting Associate Commissioner for Disability, SSA.
John Gage—President, SSA/AFGE SSA Headquarters (Local 1923).
Randolph Gaines—Acting Associate General Counsel, SSA.
Robert Green—SSA Regional Commissioner, Boston.
Joseph Gribbin—Associate Commissioner for Program and Integrity Reviews, SSA.
James Hill—President, National Treasury Employees Union (Chapter 224).
Arthur Johnson—Chief Spokesperson, SSA/AFGE General Committee.
Charles Jones—Director, Michigan Disability Determination Services.
David Knoll—President, SSA National Federation of Federal Employees Council of Consolidated Locals.
Demos Kuchulis—President, National Association of Senior Social Security Attorneys .
Antonia Lenane—Chief Policy Officer, SSA.
Huldah Lieberman—Assistant Deputy Commissioner for Operations, SSA.
Rose Lucas—President, SSA/AFGE National Council of Data Operations Centers (Council 221).
James Marshall—President, SSA/AFGE National Council of SSA/OHA Locals (Council 215).
Larry Massanari—SSA Regional Commissioner, Philadelphia.
Francis O'Byrne—President, Association of Administrative Law Judges, Inc.
Ruth Pierce—Deputy Commissioner for Human Resources, SSA.
Daniel Skoler—Associate Commissioner for Hearings and Appeals, SSA.
Witold Skwierczynski—President, SSA/AFGE National Council of SSA Field Operations Locals (Council 220).
Earl Tucker—President, SSA/AFGE National Council of Social Security Regional Offices, Program Integrity Review (Council 224).
Janice Warden—Deputy Commissioner for Operations, SSA.
Andrew Young—Deputy Commissioner for Programs, SSA.

Appendix II—Methodology

Business Process Reengineering

The Process Reengineering Program is the culmination of a rigorous SSA investigation of the reengineering efforts and methodologies of those companies, public organizations, academic institutions, and consulting firms with the most "hands on" experience in this field. The positive findings from this detailed review, combined with concerns about existing business processes within SSA and the quality of SSA service to the public, led management to the conclusion that a process reengineering effort was critical to the SSA objective of providing "world-class" administration and service.

Based largely on analysis of what has worked best in the private and public sectors, a customized reengineering methodology was developed within SSA. It uses a reengineering team approach that combines a strong "customer" focus with classic management analysis techniques, and computer modeling and simulation, to intensely review a single business process. The objective is not to make small, incremental improvements in the various pieces of the process, but to redesign it as a whole, from start to finish, so that it becomes many times more efficient and, in so doing, significantly improves SSA service to the public.

A senior SSA manager was selected to serve as Director of the Process Reengineering Program. The Director leads all SSA process reengineering efforts, is the primary liaison with the Commissioner and Executive Staff, nominates topics for examination, chairs project steering committees, and directs a small professional staff and revolving group of managers/consultants.

SSA uses special, multi-disciplinary teams of individuals to conduct reengineering analyses and identify the best ways to redesign and significantly improve processes. Teams are comprised of outstanding employees, all of whom are subject matter experts in operational, programmatic, policy, systems, administrative, and other areas relevant to the business process.

Reengineering teams focus on identifying those procedural and policy changes to the process that will: make it more claimant and service oriented; greatly increase productivity and process speed; take advantage of opportunities offered by new technology; and improve the empowerment and professional enrichment of the employees who are part of the process. Although teams follow the same basic reengineering protocol, continual customization is both expected and encouraged.

Disability Process Reengineering

Project Employees within SSA and DDS at all levels recognize that there are significant problems with the disability claims process. They are dissatisfied with the long processing times and high backlogs which result in less than satisfactory service to claimants. The disability process reengineering project has allowed those who have long worked in the process, and with claimants and their representatives, to investigate the causes of current problems. With considerable input from other employees and those outside the process, they have developed the proposal for solving those problems.

The Secretary of the Department of Health and Human Services, Donna Shalala, and the Commissioner of Social Security, Shirley Sears Chater, have placed improvements in the disability process as critical to the delivery of world-class service by SSA. They have strongly supported the work of the project team. Their adoption of the proposal will depend on the response of the employees and the public to it.

An Executive Steering Committee was formed to meet on a regular basis to provide advice to the Commissioner on development of the disability reengineering process change proposal, and to ensure that support occurred at the highest levels of the Agency. The Executive Steering Committee established the parameters and expectations for the project. The expectation goals were driven by targets set forth in the Agency Strategic Plan and are based on percentages of service and/or productivity:

Parameters and Expectations for Reengineering the Disability Determination Process (9/15/93)

Definition of Process

The "process" to be reengineered is the initial and administrative appeals system for determining an individual's entitlement to Social Security and Supplemental Security Income disability payments. It includes all actions from an individual's initial contact with SSA through payment effectuation or final administrative denial. The system for determining whether an individual continues to be entitled to receive disability payments is not part of this "process."

Rationale: The process to be reengineered must be defined broadly to increase the opportunity for improvement. The continuing disability review system is not included because it is conceptually and practically distinct from the initial disability determination process.

Parameters

Every aspect of the process except the statutory definition of disability, individual benefit amounts, the use of an administrative law judge as the presiding officer for administrative hearings, and vocational rehabilitation for beneficiaries, is within the scope of this reengineering effort. However, analysis and ideas for change should proceed and be presented on two tracks: Improvements achievable without changes in statute or regulations and innovations that may require such change.

Rationale: The timing of legislative or regulatory change is beyond SSA's control. Such change could not reasonably be expected to be implemented in less than 2 years. However, limiting the reengineering effort to aspects of the process not requiring change in statute or regulations was rejected as limiting too greatly the possibility of major improvement/innovation in the process. The two-track approach provides for both shorter term incremental improvements and longer term, more radical change.

Expectations

1. Unless otherwise specified here, the recommendations for change should be consistent with the goals and objectives set forth in the Agency Strategic Plan.

2. Recommendations for change, taken as a whole, should not cause changes in benefit outlays unless as a necessary result of improvements in service, such as more timely processing and payment of claims.

3. Process changes should improve service and/or productivity, on a combined basis, by at least 25 percent by the end of FY 1997 over levels projected in the FY 1994 budget (it would require about an additional $500 million currently to realize such improvement) and decisional accuracy should not decrease. By FY 2000 additional actions, including any necessary statutory and regulatory changes, should provide a further 25 percent improvement.

The Executive Steering Committee facilitated good ongoing communications between components and the Team, and communicated the need and reason for reengineering the disability process. They were familiar with the current process problems and were kept apprised of research completed by the Team. In February, the Executive Steering Committee was expanded to include the Presidents of the American Federation of Government Employees, the National Federation of Federal Employees, and the National Treasury Employees Union locals, councils and chapters representing SSA employees; and the Presidents of the SSA/DDS professional and management associations recognized by SSA as having an interest in disability issues.

Upon receipt of this proposal, the Executive Steering Committee will make an impact assessment, cognizant of competing pressures and implementation challenges. During the dialogue period, the Executive Steering Committee will share and discuss the proposal, provide feedback, and identify implementation questions. Based on the comments received and issues identified, they will provide advice on the next steps.

The 18 members of the Disability Reengineering Team, all of whom are SSA or State DDS employees, have varied and extensive backgrounds in all aspects of the disability program. Team members attended a high quality, intensive 3-day SSA reengineering methodology training session, and completed extensive reading assignments on reengineering. Some Team members visited organizations who had reengineered their business processes to learn about successes as well as opportunities for improvement.

The Team used the following methods to obtain the information necessary to develop a redesigned disability process.

Briefings

Members of the Team received extensive briefings from:

—All SSA components that work with any aspect of the disability process; and

—Dr. Frank S. Bloch, Professor of Law and Director of the Clinical Education Center at Vanderbilt, who discussed the results of his study comparing disability programs and processes of the United States, Canada, and Western Europe. His work encompasses eligibility requirements and program goals, benefit award structure and short-term benefits, administrative organization, and procedures for claim processing and appeals.

Scan Visits

The Team made fact-finding visits to numerous SSA and DDS offices, and to other public and private organizations throughout the country who have an interest in working with SSA to improve the disability process. Team members conducted numerous telephone interviews with representatives of offices/groups whom they could not personally visit. They also publicized surface/electronic mail addresses and fax and voice telephone numbers for those who were not contacted or had additional information to provide.

Prior to site visits/contacts, Team members provided those organizations and individuals with general information about the reengineering effort, key research areas, and some unconventional ideas about the disability process so that the interviewees would have an opportunity to think about process issues. The Team encouraged interviewees to provide open and honest opinions, suggestions, and ideas.

Appendix III contains a list of the sites visited and telephone interviews conducted.

Focus Groups

A series of 12 focus groups were held throughout the country to obtain input from members of our claimant population and the general public regarding their experiences with and expectations of the SSA disability process. The focus groups provided the Team valuable information about claimants' expectations and preferences, as well as concerns about the current process. Appendix III contains a list of the focus group sites and composition.

Benchmarking

"Internal benchmarking" refers to the identification and understanding of site-specific best practices that currently exist within the Agency and is focused on the improvement and standardization of internal operations. The Team completed this phase of benchmarking by reviewing lists of sites engaging in "best practices" which were submitted by various SSA components, and visiting or telephoning as many of these SSA and DDS offices as possible.

"External benchmarking" is essentially the same, except the hunt for best practices and proven process innovations is expanded to comparable companies and organizations outside of SSA. It is focused outside the organization and is concerned with the relative performance of one specific function or process. Appendix III contains the companies/organizations the Team used as benchmarking partners.

A valuable part of the benchmarking exercise was the opportunity to validate

assumptions related to the disability process, note issues that required further investigation, and identify potential improvement opportunities.

Process Analysis

The Team utilized a document prepared by the SSA Office of Workforce Analysis in April 1993 which outlines the "as-is" disability claim and appeal processes of SSA. The document contains a description of claim processing tasks performed by line-employees in the seven operational components that deal with the disability claim process.

Team members conducted studies on issues such as claimant burden time, gap analysis, and administrative costs. They also collected, reviewed, and researched an extensive amount of existing procedural guides, laws/regulations, studies conducted by internal and external components, processing time and quality management information, workflows, cost data, etc.

Intensive deliberations, concept debates, and analysis on ideas for change were instrumental in the creation of the redesigned process.

Computer Modeling

Computer models are close representations of work processes that, if properly constructed, allow for better understanding, testing or forecasting, and study. Team members worked with modeling professionals in SSA and the private sector to build the models used to develop assumptions about a redesigned process. The assumptions used for the proposal are shown in appendix IV.

Models were built to represent both the current and proposed processes. These models helped the Team predict the best features and performance of the new disability process; to better judge the magnitude of change from one process to another; and to do some "what-if-nothing-changes" analysis to get a feel for the impact of inactivity.

Proposal

The dominant product of the entire effort—this proposal—outlines the best process improvement and process innovation ideas from the Team. The proposal as written by the Team, will be presented to the Executive Steering Committee, and will be made widely available within SSA and the DDS community, as well as to the broadest possible public for comment.

Appendix III—Research

Logistic Accomplishments

Sites Visited: 421
States Visited: 33
Individual Interviews: 3,600+

Specific Sites

35 SSA central office components
10 regional offices, OHA ROs and ROPIRS
7 DHHS regional OGC offices
37 State DDSs
64 field offices
28 hearing offices
9 processing centers and other large installations
10 teleservice centers
14 area director offices
181 sites "external" to SSA and DDSs
6 union/management associations

Telephone Interviews

31 field offices
1 teleservice center
3 area director offices
4 hearing offices
26 DDSs
46 sites external to SSA and DDSs

BILLING CODE 4190-29-P

Internal Site Visits

REGION	RO	FO	OTHER	HO	DDS
Boston	RC Exec. Staff, RCALJ Exec. Staff, ADs, DPB	W. Warwick, RI Providence, RI Boston, MA Dorchester, MA Roxbury, MA	■ ROPIR Director ■ DQB ■ Boston, MA TSC	Boston, MA Providence, RI	Boston, MA Providence, RI
New York	RC Exec. Staff. RCALJ Exec. Staff, DPB, ADs	Jamaica, NY Boro Hall, NY Albany, NY	■ ROPIR Mgmt Staff ■ Jamaica, NY TSC ■ NEPSC	New York City, NY Albany, NY	Brooklyn, NY Newark, NJ Manhattan, NY Albany, NY New York Administrator
Philadelphia	RC Exec. Staff, RCALJ Exec. Staff, PSC (DRS) ROMCS, ADs	Wilmington, DE Philadelphia NE, PA Richmond, VA Washington "M" St., DC Uniontown, PA Pittsburgh, Penn AV, PA Huntington, WV Charleston, WV	■ ROPIR Director ■ DQB ■ MATPSC ■ Baltimore, MD TSC	Jenkintown, PA Richmond, VA Washington, D.C. Pittsburgh, PA Huntington, WV Charleston, WV	Wilmington, DE Richmond, VA Fairfax, VA Charleston, WV Baltimore, MD
Atlanta	RC Exec. Staff, RCALJ Exec. Staff, PSC, DPB, ADs	Birmingham, AL Columbia, SC Tucker, GA Little Havana, FL Nashville, TN Rome, GA Cedartown, GA	■ DQB ■ SEPSC ■ Birmingham, AL TSC ■ Ft. Lauderdale, FL TSC ■ ROPIR Director	Atlanta, GA Birmingham, AL Columbia SC Chamblee, GA Ft Lauderdale, FL Nashville, TN	Decatur, GA Birmingham, AL Columbia, SC Miami, FL Nashville, TN
Chicago	RC Exec. Staff, RCALJ Exec. Staff, DPB, ROMCS, PSC (DRS), Illinois ADs	Springfield, IL Lansing, MI Chicago NSW, IL Rochester, MN St. Paul, MN	■ ROPIR Director ■ DQB ■ Chicago, IL TSC ■ GLPSC	Chicago, IL	Springfield, IL Lansing, MI St. Paul, MN
Kansas City	RC Exec. Staff, RCALJ Exec. Staff, PSC (DRS), DPB, ROMCS Iowa AD	Kansas City, KS Topeka, KS Independence, MO Gladstone, MO St. Louis, Southside, MO	■ ROPIR Director ■ DQB ■ MAMPSC	Kansas City, MO	Topeka, KS Kansas City, MO St. Louis, MO
Dallas	RC Exec. Staff, RCALJ Exec. Staff DPB	Dallas, TX Tulsa, OK Waco, TX Oak Cliffe, TX Albuquerque, NM Huron, SD, DM only	■ ROPIR Director ■ DQB ■ Albuquerque, NM DOC ■ Grand Prairie, TX TSC ■ Albuquerque, NM TSC	Dallas North, TX Albuquerque, NM Oklahoma City, OK	Albuquerque, NM Oklahoma City, OK Arlington, TX DHU Austin, TX

REGION	RO	FO	OTHER	HO	DDS
Denver	RC Exec. Staff, RCALJ Exec. Staff, DPB, ROMCS, ADs	Greeley, CO Ft. Collins, CO Denver Dntn, CO Englewood, CO Lakewood, CO Billings, MT Sheridan, WY Rapid City, SD Yankton, SD Sioux Falls, SD Pine Ridge, SD— Outstationed CR	■ DQB ■ Golden, Co TSC ■ ROPIR Director	■ Denver, CO ■ Billings, MT ■ Processing Center, Billings MT ■ Sioux Falls, SD	Denver, CO Sioux Falls, SD
San Francisco	RC Exec. Staff, RCALJ Exec. Staff, Chief Medical Officer, ADs, DPB, PSC	SF,Civic Center, CA Sacramento, CA Tucson, AZ Phoenix, AZ Chula Vista, CA El Cajon, CA, DM only San Diego, CA, DM only Linda Vista, CA, BM only Miracle Mile, CA	■ ROPIR Director ■ DQB ■ WNPSC	Oakland, CA Los Angeles W, CA	Oakland, CA Sacramento, CA Tucson, AZ Phoenix, AZ San Diego, CA
Seattle	RC Exec. Staff, RCALJ Exec. Staff, DPB, ADs, ROMCS	Renton, WA Olympia, WA Seattle North, WA Tacoma, WA Anchorage, AK, State Mgr. only	■ ROPIR Director ■ DQB ■ Auburn, WA TSC	Seattle, WA	Renton, WA Olympia, WA Portland, OR, DDS Administrator only
National			■ AFGE ■ NCSSMA ■ NFFE ■ NTEU ■ Assoc. of Administrative Law Judges, Inc. ■ NADE		

Telephone Call Summary — Internals

REGION	FO	OTHER	HO	DDS
Boston	Worcester, MA Fall River, MA			Windsor, CT Augusta, ME Concord, NH Waterbury, VT
New York	Elmira, NY Fajardo, PR Hato Tejas, PR San Juan, PR Cayey, PR Bayamo, PR			San Juan, PR
Philadelphia	Covington, VA Welch, WV	Pittsburgh, PA AD		Washington, D.C. Harrisburg, PA
Atlanta	Augusta, GA	Tampa, FL AD Miami, FL AD	Miami, FL	Frankfort, KY Jackson, MS Raleigh, NC
Chicago	Indianapolis, IN Valparaiso, IN Pontiac, MI Madison, WI Elkhart, IN Racine, WI Detroit East, MI Detroit Conner, MI Toledo, OH Springfield, OH Oshkosh, WI Chicago South, IL Muncie, IN Chicago East, IL Highland Park, MI Grand Rapids, MI	Cleveland, OH TSC	Oak Park, MI	Indianapolis, IN Columbus, OH Madison, WI
Kansas City	Dubuque, IA Columbia, MO			Lincoln, NE Des Moines, IA
Dallas	Gretna, LA Pasadena, TX			Baton Rouge, LA Little Rock, AK
Denver				Bismarck, ND Helena, MT Sioux Falls, SD Salt Lake City, UT Cheyenne, WY
San Francisco			Phoenix, AZ Santa Barbara, CA	Honolulu, HA Carson City, NV
Seattle				Boise, ID Anchorage, AK
National		■ Black Affairs Advisory Council ■ Pacific Asian American Advisory Committee ■ National Association of Senior Social Security Attorneys ■ Hispanic Affairs Advisory Council		

Central Office Site Visits

COMMISSIONER	HUMAN RESOURCES	FINANCE ASSESSMENT AND MANAGEMENT	OPERATIONS	POLICY AND EXTERNAL AFFAIRS	PROGRAMS	SYSTEMS
Office of Information Resource Management Office of Strategic Planning	Office of Workforce Analysis	Office of Financial Policy Operations Office of Program and Integrity Review Office of Budget	Office of Operations Management and Program Integration Office of Public and Employee Service Office of Automation Support Office of Disability and International Operations Office of Central Records Operations	Office of Legislation and Congressional Affairs Office of Public Affairs Office of Research and Statistics	Office of Disability Office of Supplemental Security Income Office of Hearings and Appeals Office of Retirement and Survivors Insurance Litigation Staff Office of the Actuary	Deputy Commissioner for Systems Disability Systems Modernization Staff Office of Information Management Office of Telecommunications Office of Systems Design and Development Office of Systems Requirement

External Contacts

REGION	ADVOCACY GROUPS	LEGAL/ REPRESENTATIVE COMMUNITY	CLINICS/ HOSPITALS	MISCELLANEOUS
Boston		■ Brock Hornby, US District Judge, District of Maine, Portland, ME—telephone ■ Disability Law Center, Boston, MA	■ Chrmn., Childhood Disabilities Comm., Amer. Academy of Pediatrics, Boston, MA—telephone ■ Dr. Winkler, Neurologist, Boston, MA—telephone ■ Pres., Amer. Academy of Disability Examining Physicians, Manchester, NH—telephone ■ Dr. P. Alden, Internist, Burlington, VT—telephone	■ Office of General Counsel, Boston, MA
New York	■ Fountain House, New York, NY ■ Brooklyn Center for the Independence for the Disabled, New York, NY ■ Gay Men's Health Crisis, New York, NY ■ Hyacinth House, New York, NY ■ Coalition for the Homeless, New York, NY ■ New York City Department for Homeless Services, New York, NY ■ Access Development Corporation, New York, NY ■ Lighthouse for the Blind, New York, NY ■ VISIONS, Blind Services, New York, NY ■ Venture House, New York, NY ■ Queens Independent Living Center, New York, NY ■ New York State Advocate for the Disabled, New York, NY ■ International Center for the Disabled, New York, NY ■ Jewish Guild for the Blind, New York, NY ■ Brookdale Center for Aging, New York, NY ■ Bronx Independent Living Center, New York, NY	■ Legal Services for the Elderly, New York, New York ■ MFY Legal Services, New York, New York ■ South Brooklyn Legal Service, Brooklyn, New York ■ Barbara Samuels, Brooklyn, New York ■ Greater New York State Law Project, New York, NY ■ Legal Services, New York, NY ■ Fordham Law School, New York, NY ■ HIV Law Project, New York, NY	■ Long Island Association for AIDS Care, New York, NY ■ Cabrini Medical Center, New York, NY ■ Dr. D. DeGuzman, Internist, Newark, NJ—telephone ■ Dr. A. Goravedes, Internist, New York, NY—telephone ■ Dr. A. Marxuach, Internist, Carolina, PR—telephone	■ New York State Department of Social Services, Albany, NY ■ VA Homeless Project, New York, NY ■ New York State Workers Compensation, New York, NY ■ New York City Human Resources Admin., New York, NY ■ Mayor's Office for People with Disabilities, New York, NY ■ Vocational and Educational Services of New York, NY ■ Department of Education, Rehabilitation Services Administration, New York, NY ■ Manhattan Borough President's Office, Manhattan, NY ■ New York Commission for the Blind, New York, NY ■ New Jersey Commission for the Blind, Newark, NJ Blind, Blind,

REGION	ADVOCACY GROUPS	LEGAL/ REPRESENTATIVE COMMUNITY	CLINICS/ HOSPITALS	MISCELLANEOUS
Philadelphia	■ Whitman-Walker Clinic, Wash., DC—HIV Claims ■ ABA Legal Counsel for the Elderly, Washington, DC ■ Goodwill Industries, Pittsburgh, PA	■ Jess Leventhal, ESQ, Philadelphia, PA ■ Jenkins, Block & Mering, Richmond, VA ■ Legal Aid Bureau, Inc., Baltimore, MD ■ Allegheny County Bar Association, Pittsburgh, PA ■ Community Legal Services, Philadelphia, PA ■ Faith Angell, US Magistrate Judge, Eastern District of PA, Philadelphia, PA—telephone	■ Dr. H. Goldman, Psychiatrist, Univ. of Md., Baltimore, MD—telephone ■ Dr. S. Whitman, Psychiatrist, Hahnemann Univ. Med. School, Philadelphia, PA—telephone ■ Dr. P. McHugh, Psychiatrist, Johns Hopkins Medical Center, Baltimore, MD—telephone ■ Dr. F. Wigley, Rheumatologist, Johns Hopkins Medical Center; Frances Scott Key Medical Center, Baltimore, MD—telephone ■ Dr. C. Kennedy, Psychologist, Nat. Institute of Mental Health, Rockville, MD—telephone	■ Office of General Counsel, Philadelphia, PA ■ Vocational Rehabilitation Counselor, Wilmington, DE ■ Senator Rockefeller's Office, Huntington, WV ■ Bernard Popick, former BDI Director, Baltimore, MD—telephone ■ Art Simermeyer, former BDI Director, Baltimore, MD—telephone ■ Jean Hinckley, Former Litigation Staff Director, Baltimore, MD—telephone
Atlanta	■ Camillus House, Miami, FL—Homeless ■ Salvation Army, Ft Lauderdale, FL ■ Health Crisis Network, Miami, FL—Aids ■ AID Atlanta, Inc., Atlanta, GA ■ Retarded Citizens of Atlanta, Atlanta, GA	■ Lyle Lieberman, Esq, Miami, FL ■ Legal Services of Greater Miami, Miami, FL ■ Rudolph Patterson, Esq., Macon, GA ■ Mary Ann Lubinski, Atlanta Legal Aid, Atlanta, GA ■ Legal Services of Middle Tennessee, Nashville, TN	■ Miami Jackson Memorial Hospital, Miami, FL ■ Henderson Clinic, Ft. Lauderdale, FL ■ Dr. Azen, Internist, Miami, FL ■ Dr. Hudgins, Internist, Atlanta, GA ■ Grady Memorial Hospital, Atlanta, GA ■ Dr. Bruce Davis, CE Provider, Nashville, TN ■ Dr. David Gaw, CE Provider, Nashville, TN ■ Vanderbilt Medical Center, Nashville, TN ■ Vanderbilt Child Development Center, Nashville, TN ■ Meharry Medical School, Hubbbard Gen. Hosp., Nashville, TN ■ Dr. S. Schams, Pediatrician, Chmn, Govt. Affairs Comm., TN Chap., Amer. Academy of Pediatrics, Greenville, TN—telephone	■ Office of General Counsel, Atlanta, GA ■ HRS, Broward Co., Ft. Lauderdale, FL ■ Dade County Public Schools, Special Ed. Programs, Miami, FL ■ State of Florida Public Defender's Office, Miami, FL ■ Veterans Administration RO, Atlanta, GA ■ Workers' Comp. Dept. State of GA, Atlanta, GA ■ Congressional Staffers representing Senator Nunn and Coverdell and Representatives Linder, Gingrich, Darden, Collins, Deal, and Rowland, Atlanta, GA ■ Vanderbilt Employee Benefits Center, Nashville, TN ■ Ken Dowd, former BDI specialist, Altamonte Springs, FL—telephone FL—telephone

REGION	ADVOCACY GROUPS	LEGAL/ REPRESENTATIVE COMMUNITY	CLINICS/ HOSPITALS	MISCELLANEOUS
Chicago		■ Nancy Katz, Chicago Legal Aid Foundation, Chicago, IL ■ Southern Minnesota Legal Services, Minneapolis, MN	■ Phil Bradley, HMO, SHARE, Chicago, IL ■ Dr. S. A. Berendi, Psychiatrist, Consultative Examinations, Inc., and Assistant Professor of Psychiatry, Rush School of Medicine, Chicago, IL—telephone ■ Dr. C. Cass, Family Physician, Springfield, OH—telephone ■ Dr. J. Runke, Internist, Dir., Amer. Academy of Disability Examining Physicians, Chicago, IL—telephone ■ Dr. L. Miller, Dir., Employee Health Programs, Mayo Clinic, Rochester, MN—telephone	■ Railroad Retirement Board, Chicago, IL—telephone
Kansas City	■ Coalition for Independence, Kansas City, MO—handicap facilitator	■ Benefit Team Services, Kansas City, MO ■ Occudata Inc., Kansas City, MO ■ Wayne Radford, Topeka, KS ■ John Stevens, Topeka, KS ■ Allsup, Inc., St Louis, MO	■ Dr. J. Hart, Physical Medicine & Rehabilitation, Jefferson City, MO—telephone	■ HHS Regional Director, Kansas City, MO ■ Office of General Counsel, Kansas City, MO
Dallas		■ Carl Weisbrod, Dallas, TX	■ T. Jackson, Medical Records Supervisor, Baptist Medical Cente- Little Rock, AR—telephone ■ M. Maldonado, Release of Information Supervisor, Memorial Medical Center, Corpus Christi, TX—telephone ■ J. Hrachovy, Supervisor for Release of Information, Texas Tech Health Center, Lubbock, TX—telephone ■ M. Twiggs, Medical Records Supervisor, Acadiana Abstracting Consultants, Acadia, LA—telephone ■ P. Gregory, Medical Records Supervisor, Holt-Crock Clinic, Fort Smith, AR—telephone ■ Dr. R. Washington, Internist, Dallas, TX—telephone	■ Office of General Counsel, Dallas, TX

REGION	ADVOCACY GROUPS	LEGAL/ REPRESENTATIVE COMMUNITY	CLINICS/ HOSPITALS	MISCELLANEOUS
Denver	■ Stout St. Clinic, Denver, CO—homeless ■ Ctr. for Independent Living, Denver, CO—handicap facilitator ■ The Gathering Place, Denver, CO—homeless,abused women ■ Sioux Tribal Leaders, Rapid City, SD ■ Rosebud Indian Reservation, Rosebud, SD ■ Pine Ridge Indian Reservation, Pine Ridge, SD ■ Yankton Sioux Tribe, Wagner, SD ■ Parents Let's Unite for Kids (PLUK), Billings, MT		■ Dr. Ilke, Neo-natologist, Univ. of Colorado, Denver, CO ■ Dr. E. Alverez, Indian Health Services, Kyle, SD ■ Dr. J. Hutchinson, Psychiatrist, Southwest Colorado Mental Health Center, Durango, CO—telephone ■ Dr. D. Hubbard, Medical Director, Valley Gardens Health Center, Renton, WA—telephone	■ Rural Social Services Office, Sheridan, WY ■ BIA Social Services, Pine Ridge, SD ■ Office of General Counsel, Denver, CO

REGION	ADVOCACY GROUPS	LEGAL/ REPRESENTATIVE COMMUNITY	CLINICS/ HOSPITALS	MISCELLANEOUS
San Francisco	■ Walden House, Inc., S.F., CA—DA&A ■ Chinatown North Beach Mental Health Services, S.F., CA—treat mentally ill ■ Asian-Pacific Community Counseling, Sacramento, CA—treat mentally ill ■ Transitional Living and Support Group, Sacramento, CA—treat mentally ill ■ Advocates for the Disabled, Inc., Phoenix, AZ ■ Union of Pan Asian Communities, San Diego, CA ■ Chicano Federation of San Diego, CA ■ Project Home, Tucson, AZ ■ Tohono O'Odham Nation, Tucson, AZ—Indian Tribe ■ Superstition Mountain Mental Health, Apache Junction, AZ ■ Com-Care, Phoenix, AZ—mentally ill ■ Alpha Project, El Cajon, CA—homeless ■ Bayside Settlement House, San Diego, CA—Vietnamese, Cambodian, Laotian communities ■ San Diego AIDS Foundation, San Diego, CA ■ Advocates for the Disabled, Phoenix, AZ ■ Skid Row Mental Health, Los Angeles, CA ■ Para Los Ninos, Los Angeles, CA ■ Jorge Chuc, Community Rehab. Services, Los Angeles, CA ■ CARE Program, Long Beach, CA ■ AIDS Project Los Angeles, Hollywood, CA ■ Mental Health Assoc. & Mental Health Advocacy Services, Los Angeles, CA AZ—mentally	■ Legal Services of Northern CA, Oakland, CA ■ Tretshock, McNamara & Clymer, Tucson, AZ ■ Phil Way, International Institute, Los Angeles, CA ■ N. T. Lieu, Legal Services, Pomona, CA ■ Louise A. Monaco, Los Angeles, CA ■ Joel Leidner, Los Angeles, CA	■ La Frontera Center, Tucson, AZ ■ Dr. E. Randolph Soo Hoo, Western Occupational Health Centers, Tucson, AZ ■ George Delong, PhD., Behavioral Health System, Inc., Phoenix, AZ ■ Veterans Admin. Medical Center, Long Beach, CA ■ Dr. David Smith, Professor of Rehabilitation, Chief of Rheumatology Rehabilitation Section, University of Arizona, Tucson, AZ—telephone ■ Dr. Mary Susan Hansen, Psychiatrist, Medical Director of the Citywide Case Management Program, Tenderloin Clinic, San Francisco, CA—telephone ■ Dr. Richard Shadoan, Psychiatrist, San Francisco, CA—telephone ■ Dr. R. Grossman, Family Practice/Neurologist, Tucson, AZ—telephone ■ Dr. R. P. Liberman, Psychiatrist, West LA VA Medical Center, Los Angeles, CA—telephone ■ Dr. D. Atkin, Orthopedist, San Diego, CA—telephone ■ Dr. D. Kelsay, Internist, Loma Linda, CA—telephone ■ Dr. C. Libanati, Internist, Loma Linda School of Medicine, Loma Linda, CA—telephone	■ California State Vocational Rehab., Sacramento, CA ■ Arizona Department of Economic Security, Phoenix, AZ ■ Private Secretary, Chandler, AZ—transcription service ■ North · Communications, Santa Monica, CA

REGION	ADVOCACY GROUPS	LEGAL/ REPRESENTATIVE COMMUNITY	CLINICS/ HOSPITALS	MISCELLANEOUS
Seattle	■ Seattle Indian Center, Seattle, WA—Indian facilitator ■ Downtown Emergency Service Center, Seattle, WA—homeless	■ NOSSCR, Seattle, WA	■ MDSI Physician Group, Seattle, WA ■ Dr. James Read, Psychologist, Boise, ID—telephone ■ Dr. D. D. Smith, Internist/Pulmonologist, Everett, WA—telephone	■ Office of General Counsel, Seattle, WA ■ Resource Center for the Handicapped, Seattle, WA ■ Belltown DSHS, Seattle, WA ■ Congressional Staffers representing Senator Murray and Representatives McDermott, Dunn, and Kreidler, Seattle, WA ■ Division of Alcohol & Abuse, State of WA, Seattle, WA ■ Burk Johnson, former BDI Reg. Rep., Russellville, Oregon—telephone
National	■ Save Our Security (SOS) ■ Association of Retarded Citizens (ARC) ■ National Mental Health Association ■ AARP ■ National Alliance for Mentally Ill ■ United Cerebral Palsy Assn. ■ Older Women's League ■ Center for Health Policy	■ National Senior Citizens Law Center ■ NOSSCR, Washington, DC ■ Bazelton Center for Mental Health Law, Washington, DC ■ George Washington Center for Health Policy, Washington, DC		■ HHS, Office of the Secretary ■ Administrative Conference of the US ■ Milton Carrow, Professor of Law, George Washington University, Washington, DC ■ Eileen Bradley, Business and Administration Law Division, OGC, HHS, Washington, DC ■ Peter Spencer, National Performance Review, Washington, DC ■ Patents & Trademarks, Wash., DC ■ Office of Technology Assessments, Wash., DC ■ General Accounting Office, Wash., DC ■ Office of Inspector General, Wash., DC ■ National Academy of Social Insurance Disability Project Panel, Wash., DC ■ Department of Justice, Washington, DC—telephone Panel, Panel,

REGION	ADVOCACY GROUPS	LEGAL/ REPRESENTATIVE COMMUNITY	CLINICS/ HOSPITALS	MISCELLANEOUS
Outreach Letters and Telephone Calls		■ Judge Elizabeth Price, U.S. Attorney, Sacramento, CA ■ Jeanette Plant, U.S. Attorney, Baltimore, MD ■ Ami Hay, U.S. Attorney, Pittsburgh, PA ■ John Weinberg, U.S. District Court Judge, Seattle, WA ■ Eugene Smith, ABA, Senior Lawyers Division, Baltimore, MD ■ Clara Dworsky, ABA, Senior Lawyers Division, Houston, TX ■ Richard Wiley, ABA, Section of Administration Law and Regulations, Washington, D.C. ■ Charles Sabatino, ABA, Comm. on Legal Problems for the Elderly, Washington, D.C. ■ Nancy Coleman, ABA, Comm. on Legal Problems for the Elderly, Washington, D.C.	■ American Hospital Assoc., Wash., DC ■ American Nurses Assoc., Wash., DC ■ National Medical Assoc., Wash., DC ■ American Psychiatric Assoc., Wash., DC ■ American Psychological Assoc., Wash., DC ■ National Assoc. of Social Workers, Wash., DC ■ Child Welfare League, Wash., DC ■ American Medical Assoc., Chicago, IL ■ Society for Hospital Social Work Administrators and Directors in Health Care, Chicago, IL ■ American Academy of Disability Examining Physicians, Chicago, IL ■ 36 Additional contacts made but not listed—can be furnished upon request	■ Contacts were made with each of the 52 DDS parent agencies ■ Letters were sent to 84 professional associations and advisory groups

Focus Group Sites and Participants

SITE	DATE	GROUP COMPOSITION
Philadelphia, PA	11/30/93	DI Reconsideration SSI Initial Awards
Atlanta, GA	12/01/93	SSI Reconsideration DI Initial Awards
Denver, CO	12/02/93	SSI Claimants General Public
Bridgeport, CT	12/07/93	SSI Hearing DI Claimants
Chicago, IL	12/08/93	Spanish-Speaking Initial Awards General Public
San Jose, CA	12/09/93	DI Hearing Vietnamese-Speaking Applicants and Initial Awards

External Benchmarking Sites

ORGANIZATION	LOCATION
Health & Welfare Canada Income Security Programs	Ottawa, Canada
Anne Arundel Medical Center, Pathways Program	Annapolis, MD
Mayo Clinic Disability Program	Rochester, MN
Minneapolis Children's Hospital	Minneapolis, MN
Blue Cross of California	Los Angeles, CA
Liberty Mutual Insurance	Boston, MA
Standard Insurance Company	Portland, OR
UNUM Corporation	Portland, ME
Department of Labor and Industries, Workers' Compensation	Olympia, WA
Immigration and Naturalization, Board of Immigration Appeals	Arlington, VA
Veterans Administration, Regional Office	New York City, New York
Federal Express Corporation	Columbia, MD
Southwest Airlines	Dallas, TX
Texas Instruments	Plano, TX

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Appendix IV—Model Assumptions

Computer software packages were used to model and simulate the effects the changes in this proposal will have at both the micro (local office) and macro (national) level. Some of the general guidelines and assumptions used for the proposed process are listed below.

Due to increased public information programs, claimants will be better prepared with respect to information and documentation needs prior to filing their claim.

The time that disability claim managers spend interviewing will be reduced as a decision support system will assist them in asking the claimant impairment-specific medical and nonmedical questions. Based on triage decisions they make throughout the interview, the disability claim managers will ask the claimant only the questions that are pertinent to the decisionmaking process.

The application and medical certification forms will be scanned or electronically transferred and associated with the electronic record. A disability claim manager will only key identifying information from the application form into the electronic record.

Claim files will be much smaller in size as SSA accepts medical certification statements in lieu of extensive medical documentation.

Time to obtain medical evidence will decrease as collection focuses on core diagnostic and functional information needed to make a decision and uses a standardized form.

Changes to the current process, such as the disability claim manager concept, the predenial interview, and fully rationalized disability decisions, will increase claimant satisfaction with SSA's decisional process and ultimately decrease the appeal rate and number of refilings.

A decision support system and an electronic record will assist adjudicators to prepare notices of decision.

The percentage of claimants represented will decrease as the processing time decreases, claimant participation increases, and increased customer service leads to a higher level of claimant satisfaction and understanding of the process.

Guidelines and assumptions used for the proposed process include those listed below.

A brief description of each task is provided. The task time, shown in minutes, is the estimated time it will take employees to complete the described work. The lapse time, shown in work days, represents the amount of time between actions. Three numbers are provided: the middle number represents the most common task or lapse time, while the first and third numbers represent the low and high extremes. The task and lapse times shown represent times likely when the proposed process is fully up and running.

Percentages are shown to represent frequency of occurrences.

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Task Description	Task or Lapse Time or Frequency of Occurrence
Preliminary inquiry interviewing time	10-15-20 minutes
Lapse time between inquiry interview and scheduled appointment	3-4-5 days
Percentage of cases on which nonmedical development is deferred	50%
Application interview time	30-45-50 minutes
Preliminary nonmedical development and review time	20-40-60 minutes
Medical evidence request times:	
Medical evidence of record	10-15-20 minutes
Consultative examination	10-15-20 minutes
Functional assessment	10-15-20 minutes
Medical evidence analysis time:	
Medical evidence of record	10-15-20 minutes
Consultative examination	10-15-20 minutes
Functional assessment	20-25-30 minutes
Percentage of cases requiring medical consultation:	
Medical evidence of record	25%
Consultative examination	25%
Functional assessment	40%
Medical consultation time	25-30-45 minutes
Lapse time between request for medical consultation and completion of task	1-3-5 days
Medical evidence receipt lapse time:	
Medical evidence of record	4-10-20 days
Consultative examination	6-10-14 days
Functional assessment	6-10-14 days

Predenial interviews:	
Preliminary telephone contact time	5-10-20 minutes
Percentage of cases requesting face-to-face interview	50%
Lapse time between telephone contact and face-to-face interview	1-2-4 days
Predenial interview time	30-45-60 minutes
Percentage of cases where additional documentation submitted after predenial interview	50%
Lapse time between interview and submission of evidence	6-10-14 days
Analysis time	10-30-45 minutes
Nonmedical Development and Payment Effectuation	
Lapse time between claimant contact and pre-effectuation interview	3-4-5 days
Interview and review of evidence	60-140-180 minutes
Percentage of cases where documentation submitted after pre-effectuation interview	75%
Lapse time between interview and submission of evidence	2-10-18 days
Preparation of notices	20-30-40 minutes
Percentage of claimants filing a request for hearing	50%
Lapse time between claimant receiving denial notice and filing an appeal	1-30-60 days
Appeal request interview time	20-25-30 minutes
Initial appeal file review time	10-15-30 minutes
Lapse time between adjudication officer receiving case and telephone contact(s)	7-9-10 days
Preliminary telephone contact time with claimant and/or representative	20-30-45 minutes
Percentage of claimants represented	50%

Personal Conference:	
Percentage of cases where a personal conference is requested	50%
Lapse time between requesting and holding the personal conference	5-10-15 days
Personal conference time	30-45-60 minutes
Percentage of cases requiring time for submission of additional evidence after personal conference	30%
Lapse time between personal conference and submission of evidence	10-20-30 days
Analysis time of evidence	10-20-30 minutes
Analysis and preparation of allowance	30-45-60 minutes
Analysis and preparation of stipulations for administrative law judge (ALJ)	45-60-75 minutes
Lapse time between decision and issuance of stipulations	2 days
Scheduling of hearing	45 days after first adjudication officer-level contact
Time for ALJ prehearing review	20-40-60 minutes
Hearing:	
Length of hearing	20-40-60 minutes
Percentage of cases where ALJ grants time after the hearing for submission of evidence	10%
Lapse time between hearing and submission of evidence	10-20-30 days
Lapse time between receipt of evidence and ALJ review	1-3-5 days
Analysis of additional evidence time	20-30-40 minutes
Analysis and preparation of allowance	30-45-60 minutes
Instructions for preparation of denial decision	10-15-20 minutes
Analysis and preparation of denial decision	60-90-120 minutes
Final review and sign-off time	10-15-20 minutes

Percentage of indirect time (i.e., leave, training, etc.)	40%
Percentage of employee direct time spent on disability tasks	50%
Percentage of cases selected for own motion review	5%
Time lapse for review	8-10-12 days
Time spent on own motion review	120-180-240 minutes
Percentage of cases selected for post-effectuation quality review	5%
Time lapse for review	n/a
Miscellaneous assumptions:	
Percentage of claimants bringing evidence to the interview	70%
Sufficient to decide the case	25%
Percentage allowed	80%
Percentage denied	20%
Not sufficient to decide case	75%
Medical evidence of record obtained	10%
Functional assessment obtained	90%
Percentage of claimants not bringing evidence to the interview	30%
Percentage of claimants with medical sources	75%
Medical evidence of record obtained	10%
Functional assessment obtained	90%
Percentage of claimants with no medical sources	25%
Consultative examination obtained	100%
Overall percentage of cases allowed	60%

The following table provides a comparison of the number of different employees that are likely to make some work investment in an individual claim at each decisional level in the current and proposed processes.

Type of Claim	Current Process	Proposed Process
Initial Allowance:		
DI	26	8
SSI	19	7
Initial Denial	16	7
Recon Allowance:		
DI	36	n/a
SSI	29	n/a
Recon Denial	24	n/a
Prehearing Allowance:		
DI	n/a	11
SSI	n/a	10
Hearing Allowance:		
DI	45	14
SSI	33	13
Hearing Denial	34	12
Appeals Council Own Motion Review	43	16-17

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Appendix V—Next Steps

Proposal for an Implementation Blueprint

Building a redesigned disability claim process will not be an easy task—impacts will be felt by almost everyone internal and external to SSA who is involved in the disability claim process. Claimants, their representatives, disability advocate organizations, professional associations, SSA and DDS employees and employee representatives will feel the effects of the transition to a new way of doing business.

There will be a vast number of decisions to be made about the way the new process will be built and its infrastructure designed. Timing of the myriad decisions is crucial to ensure that required organizational, budgetary, human resource, technological, logistical, and regulatory changes occur in the proper sequence.

The Team has developed a proposal that outlines the most significant redesign implementation steps. The steps are grouped according to areas of impact. Some of the steps will be sequential while others will be simultaneous.

I. Organization

SSA will develop an organizational structure that ensures coordination and effective support of the entire disability claim process. An implementation team will be established to plan and coordinate the general aspects of the redesign changes with existing SSA components, States, unions, and professional associations.

In addition to implementing the proposed process, the implementation team will be responsible for determining the impacts on other business processes. Some of these impacts may require changes in other processes.

The following steps will be completed in order to achieve these goals:

—Obtain executive approval to proceed with implementation
—Develop disability process management structure/organization/ownership
—Build implementation team
—Develop plan for change management
—Develop method for processing current work while implementation takes place
—Outline interdependent steps of implementation
—Analyze risk factors to be encountered in meeting timeframes
—Create clear objectives to provide rapid recognition of improvement/success
—Establish tangible success scorecard
—Establish major milestones and managerial checkpoints for implementation
—Monitor progress and adjust implementation schedules accordingly for future sites
—Complete first implementation phase
—Analyze success of first phase, make necessary implementation changes and prepare for additional implementation sites
—Complete full implementation

II. Communications

SSA will develop a comprehensive communications plan that systematically and logically addresses the needs of everyone associated with the disability claim process and enhances the implementation of the redesigned process. The following steps will be completed in order to achieve this goal:

—Determine who will need to be notified of the new process and at what intervals
—Develop models needed to assist staff, claimants and stakeholders to visualize the new organization, new roles, new responsibilities
—Select communications media, including new methods or modes
—Determine communications tools to be used in providing continuing updates throughout the implementation process
—Design communications plan
—Schedule communications releases
—Begin media campaign to describe new process
—Begin media campaign to describe interim measures to get to new process
—Notify stakeholders, employees, and other interested parties of initial sites selected and implementation schedule
—Announce achievement of successfully completed milestones

III. Program Management

A. *Costs*

SSA will determine the full cost of the redesigned disability claim process, its implementation and its related impact. The following steps will be completed in order to achieve this goal:

—Estimate cost of new process operation
—Obtain necessary funding for first-phase operating expenses
—Estimate initial implementation costs
—Obtain necessary funding for first-phase implementation costs
—Determine impact of new process on current DDS budgets and indirect costs to the States and take necessary resulting actions
—Develop method for tracking and monitoring implementation costs
—Monitor process and implementation costs, making adjustments as necessary

B. *Management Information*

SSA will develop the means to gather, analyze and report the information required to operate the redesigned disability claim process. The following steps will be completed in order to achieve this goal:

—Establish management information needs for oversight agencies
—Establish management information needs for SSA
—Establish management information needs for implementation site employees
—Design and test validity of new management information reporting mechanisms
—Institute new management information system

C. *Quality*

As an important element in the redesigned process, SSA will develop new methods for assuring the delivery of world-class service. The new methods will be integrated with training, policy, and management information facets of the redesigned process. The following steps will be completed in order to achieve this goal:

—Design quality control process
—Test and validate quality control process
—Establish quality feedback mechanisms
—Institute new quality control process

D. *State Roles*

SSA will analyze comments received during the 60-day dialogue period and make determinations regarding State roles. The following steps will be completed in order to achieve this goal:

—Identify where DDS employees fit in the new process
—Determine regulatory and statutory changes needed
—Negotiate changes under current statute and regulations for implementation sites

IV. Human Resources

A. *Training*

Major changes arising out of the new way of doing business mandate that employees be fully trained to meet the needs of the new process. Much training will be done on a large scale in short periods of time. Alternate training media, e.g., satellite training, self-paced computer-based training, videotape training, etc. will be used to reach large audiences effectively. The following steps will be completed in order to achieve this goal:

—Assign lead for developing, organizing and managing the training program
—Determine national and site-specific training needs
—Determine what instructions need to be written
—Ascertain format for training materials
—Develop means to ensure current work is completed while training takes place
—Establish training timetable
—Determine teaching resource needs and source of those resources
—Obtain instructor resources
—Obtain training supplies
—Secure necessary training facilities
—Plan and coordinate training sessions
—Begin training
—Monitor training results and make adjustments as necessary
—Complete all initial training activities

B. *Personnel*

SSA will effectively prepare for and, to the extent possible, minimize negative effects of the transition to the redesigned process on employees. Plans will consider the effect on the work environment, career enhancements, job responsibilities, possible workforce shifts, and performance evaluation. The following steps will be completed:

—Determine volume and qualifications of staff needed to perform new process
—Create, modify, or eliminate job types for the new process
—Develop change management assistance for employees
—Develop performance monitoring systems and incentives
—Determine tools employees need to perform new process
—Develop position descriptions and performance plans
—Establish long-term plan to ensure national availability of qualified staff
—Analyze staff availability at implementation sites for new process and old process
—Determine anticipated costs of moving personnel to work sites, temporarily and/or permanently
—Determine staffing needs
—Obtain necessary funding to move staff
—Obtain tools for employees
—Establish local management and key staff teams
—Select remaining staff
—Move staff as necessary
—Begin new process

V. Statutory/Regulatory/Policy

A. *Policy*

Extensive policy changes will take place prior to and during process implementation. As regulatory and statutory modifications occur, procedural re-writes will address their impact on SSA claim processing policy. New, more effective means of organizing and issuing Agency policy will be used to accomplish these tasks. The following steps will be completed in order to achieve these goals:

—Ascertain what procedures and workflows need to be modified, eliminated, or established
—Determine appropriate policy and procedure format(s)
—Develop screens and forms to be incorporated in new process
—Determine methods for policy and procedure dissemination
—Develop method for monitoring policy implementation
—Design new workflow
—Write procedures needed to nationally implement immediate changes
—Issue new procedures
—Monitor, analyze and re-write procedures as necessary
—Write procedures to support regulatory and statutory changes
—Issue long-term procedures
—Monitor, analyze, and re-write procedures as necessary

B. *Statutory/Regulatory*

A large number of regulations and statutory sections will need to be modified to support the implementation of the redesigned process. SSA will develop faster, more effective means for gaining the necessary changes. The following steps will be completed in order to achieve this goal:

—Write necessary regulations to support new process
—Propose elimination of unnecessary regulations
—Obtain final approval for regulatory changes
—Seek changes to necessary statutes to support new process
—Congressional approval of statutory changes
—Establish methods for statutory and regulatory change dissemination
—Disseminate statutory and regulatory changes to all necessary parties

VI. Logistics

A. *Implementation sites*

Implementation will impact the physical work environment. Decisions on number, location, size, and layout of offices will be designed into the implementation plan. The following steps will be taken:

—Ascertain type of sites needed
—Analyze demographic, geographic, and fiscal considerations for site selection
—Select site management team to orchestrate site preparation
—Determine number of first-implementation sites
—Recommend implementation sites
—Receive implementation site approval
—Evaluate implementation facilities for necessary space and layout modifications
—Determine new or additional equipment and furniture needs at implementation sites
—Evaluate supplies and forms needed for new process
—Obtain funding for site work, supplies and equipment
—Prepare site and equipment leases
—Order supplies and forms needed for new process
—Order new equipment
—Complete site preparation work at implementation facilities
—Install equipment
—Deliver supplies and forms to sites
—Deliver new employees' possessions

B. *Technology*

Increased use of automated processes; decisional support software; electronic claimant records; electronic interaction between SSA, claimants, and the medical community; and telecommunications in the redesigned process dictates that SSA expand and accelerate the current comprehensive technology design plan. The following steps will be completed to achieve these goals:

—Review and modify pertinent Agency tactical plans
—Analyze impact of change on computer programs currently being used or planned in SSA
—Reevaluate hardware and software needs
—Modify existing SSA software to support the new process
—Develop and validate new software
—Procure hardware
—Install necessary hardware
—Install software
—Test hardware and software, making necessary adjustments
—Implement new systems

Summary of Current Statutory and Regulatory Provisions Affected by the New Disability Process

Title II of the Social Security Act—Disability Determinations: Section 221(a) through (j)—Disability Insurance Benefit Payments (Definition of Disability): section 223(d)(5)(B).

Title XVI of the Social Security Act—Meaning of Terms (Aged, Blind, or Disabled Individual): section 1614(a)(3)(G)—Administration: section 1633.

Regulations (parts 404, 416 and 422)

The following sections of subpart G of Reg. No. 404 and subpart C of Reg. No. 416:

§§ 404.610/416.310 What makes an application a claim for benefits.
§ 404.614 When an application or other form is considered filed.
§ 416.325 When an application is considered filed.

The following sections of subpart J of Reg. No. 404 and subpart N of Reg. No. 416:

§§ 404.900/416.1400 Introduction.
§§ 404.902/416.1402 Administrative actions that are initial determinations.
§§ 404.904/416.1404 Notice of the initial determination.
§§ 404.905/416.1405 Effect of an initial determination.
§§ 404.907/416.1407 Reconsideration—general.
§§ 404.908/416.1408 Parties to a reconsideration.
§§ 404.909/416.1409 How to request reconsideration.
§§ 404.913/416.1413 Reconsideration procedures.
§ 416.1413a Reconsiderations of initial determinations on applications.
§§ 404.929/416.1429 Hearing before an administrative law judge—general.
§§ 404.930/416.1430 Availability of a hearing before an administrative law judge.
§§ 404.932/416.1432 Parties to a hearing before an administrative law judge.
§§ 404.933/416.1433 How to request a hearing before an administrative law judge.
§§ 404.935/416.1435 Submitting evidence prior to a hearing before an administrative law judge.
§§ 404.936/416.1436 Time and place for a hearing before an administrative law judge.
§§ 404.938/416.1438 Notice of a hearing before an administrative law judge.
§§ 404.939/416.1439 Objections to the issues.
§§ 404.940/416.1440 Disqualification of the administrative law judge.
§§ 404.941/416.1441 Prehearing case review.
§§ 404.944/416.1444 Administrative law judge hearing procedures—general.
§§ 404.946/416.1446 Issues before an administrative law judge.
§§ 404.948/416.1448 Deciding a case without an oral hearing before an administrative law judge.
§§ 404.955/416.1455 The effect of an administrative law judge's decision.
§§ 404.960/416.1460 Vacating a dismissal of a request for a hearing before an administrative law judge.
§§ 404.961/416.1461 Prehearing and posthearing conferences.
§§ 404.967/416.1467 Appeals Council review—general.
§§ 404.968/416.1468 How to request Appeals Council review.
§§ 404.969/416.1469 Appeals Council initiates review.
§§ 404.970/416.1470 Cases the Appeals Council will review.
§§ 404.971/416/1471 Dismissal by the Appeals Council.
§§ 404.972/416.1472 Effect of dismissal of request for Appeals Council review.
§§ 404.973/416.1473 Notice of Appeals Council review.
§§ 404.976/416.1476 Procedures before Appeals Council on review.
§§ 404.977/416.1477 Case remanded by the Appeals Council.
§§ 404.979/416.1479 Decision of Appeals Council.
§§ 404.981/416.1481 Effect of Appeals Council's decision or denial of review.
§§ 404.982/416.1482 Extension of time to file action in Federal district court.
§§ 404.992/416.1492 Notice of a revised determination or decision.
§§ 404.993/416.1493 Effect of revised determination or decision.

The following sections of subpart P of Reg. No. 404 and subpart I of Reg. No. 416:

§§ 404.1501/416.901 Scope of subpart.
§§ 404.1502/416.902 General definitions and terms for this subpart.
§§ 404.1503/416.903 Who makes disability and blindness determinations.
§§ 404.1505/416.905 Basic definition of disability.
§§ 404.1511/416.911 Definition of a disabling impairment.
§§ 404.1512/416.912 Evidence of your impairment.
§§ 404.1513/416.913 Medical evidence of your impairment.
§§ 404.1515/416.915 Where and how to submit evidence.
§§ 404.1517/416.917 Consultative examination at our expense.
§§ 404.1519/416.919 The consultative examination.
§§ 404.1519a/416.919a When we will purchase a consultative examination and how we will use it.
§§ 404.1519k/416.919k Purchase of medical examinations, laboratory tests, and other services.
§§ 404.1519m/416.919m Diagnostic tests or procedures.
§§ 404.1519n/416.919n Informing the examining physician or psychologist of examination scheduling, report content, and signature requirements.
§§ 404.1519q/416.919q Conflict of interest.
§§ 404.1519s/416.919s Authorizing and monitoring the consultative examination.
§§ 404.1519t/416.919t Consultative examination oversight.
§§ 404.1520/416.920 Evaluation of disability in general.
§§ 404.1520a/416.920a Evaluation of mental impairments.
§§ 404.1521/416.921 What we mean by an impairment(s) that is not severe.
§§ 404.1522/416.922 When you have two or more unrelated impairments—initial claims.
§§ 404.1523/416.923 Multiple impairments.
§ 416.924 How we determine disability for children.
§ 416.924a. Age as a factor of evaluation in childhood disability.
§ 416.924b Functioning in children.
§ 416.924c Other factors we will consider.
§ 416.924d Individualized functional assessment for children.
§ 416.924e Guidelines for determining disability using the individualized functional assessment.
§ 404.1525/416.925 Listing of impairments in Appendix 1.
§§ 404.1526/416.926 Medical equivalence.
§ 416.926a Equivalence for children.
§§ 404.1527/416.927 Evaluating medical opinions about your impairment(s) or disability.
§§ 404.1529/416.929 How we evaluate symptoms, including pain.
§ 416.931 The meaning of presumptive disability or presumptive blindness.
§ 416.932 When presumptive payments begin and end.
§ 416.933 How we make a finding of presumptive disability or presumptive blindness.
§ 416.934 Impairments which may warrant a finding of presumptive disability or presumptive blindness.
§§ 404.1545/416.945 Your residual functional capacity.
§§ 404.1546/416.946 Responsibility for assessing and determining residual functional capacity.
§§ 404.1560/416.960 When your vocational background will be considered.
§§ 404.1561/416.961 Your ability to do work depends upon your residual functional capacity.
§§ 404.1562/416.962 If you have done only arduous unskilled physical labor.
§§ 404.1563/416.963 Your age as a vocational factor.
§§ 404.1564/416.964 Your education as a vocational factor.
§§ 404.1565/416.965 Your work experience as a vocational factor.
§§ 404.1566/416.966 Work which exists in the national economy.
§§ 404.1567/416.967 Physical exertion requirements.
§§ 404.1568/416.968 Skill requirements.
§§ 404.1569/416.969 Listing of Medical-Vocational Guidelines in Appendix 2.
§§ 404.1569a/416.969a Exertional and nonexertional limitations.
§§ 404.1574/416.974 Evaluation guides if you are an employee.
§§ 404.1575/416.975 Evaluation guides if you are self-employed.
§§ 404.1584/416.984 Evaluation of work activity of blind people.
Appendix 1 Listing of Impairments.
Appendix 2 Medical-Vocational Guidelines.

The entire subpart Q of Reg. No. 404 and the entire subpart J of Reg. No. 416.

The following sections of subpart R of Reg. No. 404 and subpart O of Reg. No. 416:

§§ 404.1700/416.1500 Introduction.
§§ 404.1703/416.1503 Definitions.
§§ 404.1705/416.1505 Who may be your representative.
§§ 404.1707/416.1507 Appointing a representative.
§§ 404.1710/416.1510 Authority of a representative.

§§ 404.1715/416.1515 Notice or request to a representative.
§§ 404.1720/416.1520 Fee for a representative's services.
§§ 404.1725/416.1525 Request for approval of a fee.
§§ 404.1728/416.1528 Proceedings before a State or Federal court.
§§ 404.1730/416.1530 Payment of fees.
§§ 404.1735/416.1535 Services in a proceeding under title II of the Act.
§§ 404.1740/416.1540 Rules governing representatives.
§§ 404.1745/416.1545 What happens to a representative who breaks the rules.

The following sections of subpart B of Reg. No. 422:

§ 422.130 Claim Procedure.
§ 422.140 Reconsideration of initial determination.

The following sections of subpart C of Reg. No. 422:

§ 422.203 Hearings.
§ 422.205 Review by Appeals Council.
§ 422.210 Court review.

The following sections of subpart F of Reg. No. 422:

§ 422.505 Applications and related forms for retirement, survivors, and disability insurance benefit programs.
§ 422.525 Where applications and other forms are available.
§ 422.527 Private printing and modification of prescribed applications and other forms.

Appendix VI—Examples of Forms and Publications

Disability Information Packets

All forms that a claimant will need to file an application for benefits will be contained in the disability information packet which SSA will make available to the public. Claimants may obtain these packets by visiting or calling any local SSA office or calling the toll-free 800 telephone number. SSA will also make these packets available at other public locations such as post offices, public libraries, and local, State and Federal offices. Bulk supplies of the packets will also be available to third parties who play a role in the intake process. The information packet will contain two forms—an application and a medical certification form. During the Team's research, which included benchmarking activities, it was discovered that other government agencies and private organizations successfully utilize this approach.

Application Form

This is a "starter" form that serves the purpose of initiating the application process. It will solicit basic identification data regarding the claimant as well as information concerning the nature of the benefits sought (i.e., DI, SSI, children's, widow's, etc.). The application form will ask for minimal information, will be easily understood, and will require little or no assistance. The claimant's signature will be required on the form to meet the legal requirements of a formal "application".

Medical Certification Form

This form is for completion by the claimant's primary treating source. Rather than systematically collecting all medical evidence of record, SSA will use this form to solicit core diagnostic and functional information from the treating source. The form will use both narrative and "check box" formats to elicit identification of each of the claimant's medically determinable impairments; the objective data (signs, symptoms, clinical and laboratory findings) supporting the diagnoses; the treatment prescribed and response; the onset and expected duration of the impairments; and an assessment of the claimant's ability to perform work-related activities. The treating source signature certifies that the information is accurate and based upon records within their possession, which they agree to promptly furnish if requested.

The medical certification concept is similar to that used by many private disability insurance carriers, workers' compensation programs throughout the country, and the Canadian Government. The SSA medical report builds upon the concept of the forms used by other organizations to target the specific information called for in the new process.

SSA Publications

SSA rules, pamphlets, factsheets, flyers, posters, and other materials, will be printed and available for distribution throughout the country at designated public places accessible to claimants, representatives, the medical community, public and private social service agencies, third parties, and advocacy groups. This will ensure that these partners in the new process can be well informed and will allow SSA to achieve its goal of providing world-class service to its customers.

Appendix VII—Process Change Recommendations That Were Outside the Parameters

In conducting the internal and external scans, the Reengineering Team received many ideas and suggestions for change. The ideas that follow are recurring suggestions for change that the Reengineering Team did not consider because they exceeded the scope of the Team's mission or the parameters established by the Executive Steering Committee. They may be considered for further study or action by SSA or Congress, as appropriate. Inclusion here does not constitute endorsement by the Reengineering Team.

Time-Limited Benefits

Consider time-limited benefits which would subject individuals, whose impairments are expected to improve or where medical improvement is possible, to automatic benefit termination after a specified time. Duration of entitlement would depend on the nature of the impairment, i.e., the timeframe could vary according to the impairment the same way the current continuing disability review diary duration does. Individuals would be notified at the time their claims are allowed how long they will receive benefits. Before the automatic termination of benefits, SSA would notify individuals when benefits would end, and explain that they must refile or submit new medical information that confirms they continue to meet the definition of disability. Time-limited benefits would counteract the mindset that disability benefits are permanent. To be successful, time-limited benefits would have to be linked to a return to work program or participation in vocational rehabilitation services.

Integration of Mandatory Vocational Rehabilitation Services for Claimants

Consider focusing more resources on enforcing vocational rehabilitation participation, and discussing rehabilitation and return to work earlier in the application process. At the time of an initial determination, a vocational rehabilitation program should be prescribed and required for the claimant to follow during the period of entitlement. Special efforts should be made so that rehabilitation agencies would work with disabled children, drug addicts, and alcoholics. If SSA determines that the rehabilitation program is not proceeding as scheduled, a new decision, based on current information, would be made regarding the claimant's ability to successfully continue and complete the rehabilitation program.

Changes in Payment of Benefits to Certain SSI Claimants

Consider providing benefits to some SSI claimants in the form of program support rather than cash. For example, some children might benefit from a system for vouchering or crediting funds for medical or therapeutic treatment, remedial education, and/or job training. This would present an opportunity for disabled children to get additional

assistance with education, learn job skills and maximize their potential. Disabled child recipients should be required to stay in school, or if homebound, continue in an educational program as a requirement to continue receiving benefits. Similarly, for adults receiving disability based on substance addiction, a system could be established for vouchering or crediting funds for medical or therapeutic treatment, education, job training, and for food, clothing, and lodging.

Incentives for the Medical Community to Provide Evidence on Their Patients or to be Consultative Examination Providers

To enhance SSA's ability to obtain needed medical evidence, consider enacting legislation to require release of medical information to SSA without the need for a signed consent form or based on signature in file and to require timely release of any physician or hospital records produced or maintained by a Medicare/Medicaid provider. Legislation should also be enacted to allow physicians to repay their federally funded medical school loans by working as consultative examination providers or SSA medical consultants. SSA should also consider seeking a special tax credit system for reimbursement to medical providers for evidence of record on their patients. Physicians who opt for this new tax credit would be required to participate in training on completion of forms and to submit timely and accurate information.

Establish One Court to Handle All SSA Disability Cases

Consider supporting the establishment of a new Federal court of appeals with sole jurisdiction for reviewing the final decision of the Secretary in disability cases. District courts would no longer have jurisdiction in disability cases.

Eliminate SSA's Involvement With Representative Payees

Consider providing direct payment to all adult claimants unless they have a legal representative or have been found legally incompetent. SSA would no longer develop for capability or make determinations as to whether benefits are being used in an individual's best interests.

Change the Administrative Law Judge Position to a Hearings Officer Position

There are a number of Federal agencies whose administrative appeals processes use hearing officers or administrative judges who are not appointed as administrative law judges pursuant to the Administrative Procedure Act. Because the SSA hearing process is nonadversarial and informal, it was suggested that there is no need for an Administrative Procedure Act-protected administrative law judge.

Eliminate the Two-Year Waiting Period for Medicare

DI claimants must be eligible for disability benefits for two years before they can qualify for Medicare, while in most States SSI claimants receive Medicaid concurrently with the SSI award. Claimants who file for both DI and SSI may receive Medicaid coverage with SSI, but may lose it when DI payments begin after the end of the 5-month waiting period. In many cases, the claimant's primary concern is for medical care; enabling access to appropriate medical care could lead to or speed up medical recovery.

Require Claimants to Establish That Employers Have Made all the Accommodations Required Under the Americans With Disabilities Act

The Americans with Disabilities Act defines an individual with a disability as someone who has, or is perceived to have, or who has a history of a physical or mental impairment that substantially limits one or more major life activities. Any employer with 25 or more employees (15 or more employees as of June 26, 1994) is prohibited from discriminating against qualified job applicants and employees with disabilities. Qualified individuals are those who can perform the essential functions of the job they hold or desire, with or without reasonable accommodations. Consider requiring individuals who are qualified under the Americans with Disabilities Act to have a signed statement from their former employer which outlines the steps that have been taken to make reasonable accommodations for the disability.

Provide Presumptive Disability Payments in DI Claims

Consider providing presumptive disability benefits to DI claimants. Presumptive disability benefits are now provided prior to final decision to SSI claimants who are likely to be allowances. These payments can be given for up to six months and, if the claimant is denied, no repayment of the benefit is required. There is a growing number of DI claimants with the same financial needs as SSI claimants.

Establish a Family Maximum for SSI Benefits

Consider establishing a family maximum for SSI benefits as exists in DI. With the increasing number of children receiving SSI disability benefits, consideration should be given to equalizing Federal cash support to DI and SSI families.

Eliminate the Waiting Period for DI Benefits

Consider eliminating the five-month waiting period. The same definition of disability is used for both DI and SSI claimants, yet DI claimants must serve a five-month waiting period before they are eligible for DI disability benefits.

Limit Payment of Disability Benefits to Residents of the United States

Consider ceasing the payment of disability benefits to people who reside outside the United States. The vocational factors that are considered in determining ability to work are based on the United States national job economy and it should not be assumed that an individual would meet the SSA definition of disability in another labor market.

Change the Earnings Amounts for Determining Trial Work Period Months

Consider setting more reasonable levels for determining trial work period months to encourage claimants to attempt returning to work.

Use a Single Earnings Test for All Claimants

Consider standardizing the annual work test for all claimants under age 65. This would serve as an incentive for claimants to return to work and reduce the number of work issue continuing disability reviews that need to be developed.

Reduce the Number of Actions Required to Process Multiple Benefit Payments on One Social Security Number

Issuance of multiple payments on one social security number is very labor intensive. To simplify the process, consider adopting one of the following options: Issue a single check for all benefits due on the beneficiary's account number to the beneficiary and require him/her to disburse monies to the auxiliaries; pay total family benefits to the head of the household (if other than the beneficiary) which would eliminate multiple checks, multiple letters, and multiple payment actions dealing with the family unit; or pay a flat rate for each auxiliary. This would eliminate the need to calculate auxiliary benefits on each account.

Change the Definition of Disability to Eliminate the Consideration of Age, Education, and Previous Work in Determining Disability

Reconsider the definition of disability so that only medical factors are considered. With the enactment of the ADA, the number of job opportunities and the availability of services to people with disabilities has been greatly enhanced and determining disability should be based on a strict medical test

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Friday
April 15, 1994

Part III

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of Federal Housing Enterprise Oversight

[Docket No. N–94–3751; FR–3706–N–01]

DEPARTMENT OF JUSTICE

DEPARTMENT OF THE TREASURY

Office of the Comptroller of the Currency

[Docket No. 94–04]

Office of Thrift Supervision

[Docket No. 94–41]

FEDERAL RESERVE SYSTEM

[Docket No. R–0834]

FEDERAL DEPOSIT INSURANCE CORPORATION

FEDERAL HOUSING FINANCE BOARD

FEDERAL TRADE COMMISSION

NATIONAL CREDIT UNION ADMINISTRATION

Policy Statement on Discrimination in Lending

AGENCIES: Department of Housing and Urban Development; Office of Federal Housing Enterprise Oversight; Department of Justice; Office of the Comptroller of the Currency, Treasury; Office of Thrift Supervision, Treasury; Board of Governors of the Federal Reserve System; Federal Deposit Insurance Corporation; Federal Housing Finance Board; Federal Trade Commission; National Credit Union Administration.

ACTION: Notice of approval and adoption of "Policy Statement on Discrimination in Lending"; and Solicitation of Comments regarding its application.

SUMMARY: The Department of Housing and Urban Development (HUD), the Office of Federal Housing Enterprise Oversight (OFHEO), the Department of Justice (DOJ), the Office of the Comptroller of the Currency (OCC), the Office of Thrift Supervision (OTS), the Board of Governors of the Federal Reserve System (Board); Federal Deposit Insurance Corporation (FDIC); Federal Housing Finance Board (FHFB), the Federal Trade Commission (FTC), and the National Credit Union Administration (NCUA) (collectively, "the Agencies") have adopted a statement entitled "Policy Statement on Discrimination in Lending" that describes the general principles that these Agencies will consider to identify lending discrimination in violation of the Equal Credit Opportunity Act or the Fair Housing Act. The principles outlined are general in nature. Their application in specific situations will depend on the facts involved and is subject to continuing development. The Agencies welcome comments about application of the principles to specific policies and practices. The Agencies anticipate providing further clarification and elaboration on the application of the principles in the future.

DATES: *Effective date:* April 15, 1994.

Comment due date: June 14, 1994.

ADDRESSES:

HUD: Comments should be directed to the Rules Docket Clerk, Office of General Counsel, Room 10276, Department of Housing and Urban Development, 451 Seventh Street SW., Washington, DC 20410. Communications should refer to the above title.

OFHEO: Comments should be directed to: Communications and Public Affairs, Office of Federal Housing Enterprise Oversight, 1700 G Street, Fourth Floor, NW., Washington, DC 20552.

DOJ: Comments should be mailed to: U.S. Department of Justice, Housing and Civil Enforcement Section, P.O. Box 65998, Washington, DC 20035–5998.

OCC: Comments should be directed to: Communications Division, Office of the Comptroller of the Currency, 250 E Street SW., Washington, DC 20219, Attention Docket No. 94–04. Comments will be available for public inspection and photocopying at the same location.

OTS: Send comments to: Director, Information Services Division, Public Affairs, Office of Thrift Supervision, 1700 G Street NW., Washington, DC 20552, Attention Docket No. 94–41. These submissions may be hand delivered to 1700 G Street NW., from 9 a.m. to 5 p.m. on business days; they may be sent by facsimile transmission to FAX number (202) 906–7755. Comments will be available for inspection at 1700 G Street NW., from 1 p.m. until 4 p.m. on business days. Visitors will be escorted to and from the Public Reading Room at established intervals.

BOARD: Comments should refer to Docket No. R–0834 and mailed to William W. Wiles, Secretary, Board of Governors of the Federal Reserve System, Washington, DC 20551. Comments addressed to Mr. Wiles may also be delivered to room B–2222 of the Eccles Building between 8:45 a.m. and 5:15 p.m. weekdays, or to the guard station in the Eccles Building courtyard entrance on 20th Street NW (between Constitution Avenue and C Street NW) at any time. Comments may be inspected in room MP–500 of the Martin Building between 9 a.m. and 5 p.m. weekdays, except as provided in the Board's rules regarding the availability of information (12 CFR 261.8).

FDIC: Comments should be directed to: Robert E. Feldman, Acting Executive Secretary, FDIC, 550 17th Street NW., Washington, DC 20429. They may be hand delivered to room 402, 1776 F Street NW., Washington DC between 8:30 a.m. and 5:15 p.m. on business days. Comments may also be faxed to (202) 898–3838.

FHFB: Comments should be directed to: Elaine L. Baker, Associate Director and Executive Secretary, Federal Housing Finance Board, 1777 F Street NW., Washington, DC 20006.

FTC: Comments may be filed in person or mailed to: Secretary, Federal Trade Commission, 6th Street and Pennsylvania Avenue NW., Washington, DC 20580.

NCUA: Comments should be directed to: Mr. Michael J. McKenna, Staff Attorney, Office of General Counsel, National Credit Union Administration, 1775 Duke Street, Alexandria, VA 22314–3428.

FOR FURTHER INFORMATION CONTACT:

HUD: Peter Kaplan, Director, Office of Regulatory Initiatives and Federal Coordination, (202) 708–2904 (voice) or 1–800–877–TDDY (Federal Information Relay Service).

OFHEO: Kevin G. Chavers, Chief of Staff, Office of Federal Housing Enterprise Oversight, (202) 414–3800.

DOJ: Alexander C. Ross, (202) 514–2303, or Richard J. Ritter, (202) 514–4739, Housing and Civil Enforcement Division, or (202) 514–0383 (TDD).

OCC: R. Russell Bailey, Fair Lending Specialist, Compliance Management, (202) 874–4446; Margaret Hesse, Attorney, Bank Operations and Assets Division, (202) 874–4460.

OTS: Timothy R. Burniston, Deputy Assistant Director for Policy, (202) 906–5629; David H. Enzel, Special Counsel, (202) 906–6844; or Vicki Hawkins-Jones, Senior Attorney, (202) 906–7034.

BOARD: Glenn E. Loney, Associate Director, (202) 452–3585; or Michael S. Bylsma, Senior Attorney, (202) 452–3667; Division of Consumer and Community Affairs, Board of Governors of the Federal Reserve System.

FDIC: Ken A. Quincy, Chief, Compliance and Special Review Section, Division of Supervision, (202) 898–6753; Bobbie Jean Norris, Deputy Director, Office of Consumer Affairs, (202) 898–6760; Ann Loikow, Counsel, (202) 898–3796.

FHFB: Sylvia C. Martinez, Director, Housing Finance Directorate, (202) 408–2825 (voice) or (202) 408–2579 (TDD).

FTC: Peggy L. Twohig, Assistant Director for Credit Practices, Bureau of Consumer Protection, (202) 326–3224.

NCUA: Robert M. Fenner, General Counsel, or Michael J. McKenna, Staff Attorney, Office of General Counsel, (703) 518–6540.

SUPPLEMENTARY INFORMATION: The following Federal Agencies—HUD, OFHEO, DOJ, OCC, OTS, the Board, FDIC, FHFB, FTC, and the NCUA—sharing a concern that some prospective homebuyers and other borrowers may be experiencing discriminatory treatment in their efforts to obtain loans, formed an Interagency Task Force on Fair Lending to establish uniform policy against discriminatory lending.

On March 8, 1994, the Interagency Task Force on Fair Lending met to approve or recommend approval to their respective Agencies of the "Policy Statement on Discrimination in Lending," published in this notice, as a statement of the Agencies' general position on the Equal Credit Opportunity Act and the Fair Housing Act for purposes of administrative enforcement of those statutes. The Policy Statement is intended to be consistent with those statutes and their implementing regulations and provide guidance to lenders seeking to comply with them. The Policy Statement does not create or confer any substantive or procedural rights on third parties which could be enforceable in any administrative or civil proceeding.

The Agencies have all approved the Policy Statement and welcome comments from the public about application of the principles set forth in the Policy Statement to specific lending policies and practices. The Agencies anticipate providing further clarification and elaboration on the application of the fair lending principles, and these comments will be taken into consideration as they do so.

Accordingly, the following policy statement is the Policy Statement on Discrimination in Lending adopted by the Interagency Task Force on Fair Lending.

Policy Statement on Discrimination in Lending

The Department of Housing and Urban Development ("HUD"), the Department of Justice ("DOJ"), the Office of the Comptroller of the Currency ("OCC"), the Office of Thrift Supervision ("OTS"), the Board of Governors of the Federal Reserve System (the "Board"), the Federal Deposit Insurance Corporation ("FDIC"), the Federal Housing Finance Board ("FHFB"), the Federal Trade Commission ("FTC"), the National Credit Union Administration ("NCUA"), and the Office of Federal Housing Enterprise Oversight ("OFHEO") (collectively, "the Agencies") are concerned that some prospective home buyers and other borrowers may be experiencing discriminatory treatment in their efforts to obtain loans. The 1992 Federal Reserve Bank of Boston study on lending discrimination, Congressional hearings, and agency investigations have indicated that race is a factor in some lending decisions. Discrimination in lending on the basis of race or other prohibited factors is destructive, morally repugnant, and against the law. It prevents those who are discriminated against from enjoying the benefits of access to credit. The Agencies will not tolerate lending discrimination in any form. Further, fair lending is not inconsistent with safe and sound operations. Lenders must continue to ensure that their lending practices are consistent with safe and sound operating policies.

This policy statement applies to all lenders, including mortgage brokers, issuers of credit cards, and any other person who extends credit of any type. The policy statement is being issued for several reasons, including:

- To provide guidance about what the agencies consider in determining if lending discrimination exists; and
- To provide a foundation for future interpretations and rulemakings by the Agencies.

A number of federal statutes seek to promote fair lending. For example, the Home Mortgage Disclosure Act ("HMDA"), 12 U.S.C. 2801 *et seq.*, seeks to prevent lending discrimination and redlining by requiring public disclosure of certain information about mortgage loan applications. The Community Reinvestment Act ("CRA"), 12 U.S.C. 2901 *et seq.*, seeks affirmatively to encourage institutions to help to meet the credit needs of the entire community served by each institution covered by the statute, and CRA ratings take into account lending discrimination by those institutions. The Americans with Disabilities Act, 42 U.S.C. 12101 *et seq.*, prohibits discrimination against persons with disabilities in the provision of goods and services, including credit services. This policy statement, however, is based upon and addresses only the Equal Credit Opportunity Act ("ECOA"), 15 U.S.C. 1691 *et seq.*, and the Fair Housing Act ("FH Act"), 42 U.S.C. 3601 *et seq* , the two statutes that specifically prohibit discrimination in lending.

This policy statement has been approved and adopted by the signatory Agencies listed above as a statement of the Agencies' general position on the ECOA and the FH Act for purposes of administrative enforcement of those statutes. It is intended to be consistent with those statutes and their implementing regulations and to provide guidance to lenders seeking to comply with them. It does not create or confer any substantive or procedural rights on third parties which could be enforceable in any administrative or civil proceeding.

This policy statement will discuss what constitutes lending discrimination under these statutes and answer questions about how the Agencies will respond to lending discrimination and what steps lenders might take to prevent discriminatory lending practices.

A. Lending Discrimination Statutes and Regulations

(1) The ECOA prohibits discrimination in any aspect of a credit transaction. The ECOA is not limited to consumer loans. It applies to any extension of credit, including extensions of credit to small businesses, corporations, partnerships, and trusts.

The ECOA prohibits discrimination based on:

- Race or color;
- Religion;
- National origin;
- Sex;
- Marital status;
- Age (provided the applicant has the capacity to contract);
- The applicant's receipt of income derived from any public assistance program; and
- The applicant's exercise, in good faith, of any right under the Consumer Credit Protection Act.

The Federal Reserve Board's Regulation B, found at 12 CFR part 202, implements the ECOA. Regulation B describes lending acts and practices that are specifically prohibited, permitted, or required. Official interpretations of the regulation are found in Supplement I to 12 CFR part 202.

(2) The FH Act prohibits discrimination in all aspects of residential real-estate related transactions, including, but not limited to:

- Making loans to buy, build, repair or improve a dwelling;
- Purchasing real estate loans;
- Selling, brokering or appraising residential real estate; and
- Selling or renting a dwelling.

The FH Act prohibits discrimination based on:

- Race or color;

- National origin;
- Religion;
- Sex;
- Familial status (defined as children under the age of 18 living with a parent or legal custodian, pregnant women, and people securing custody of children under 18); and
- Handicap.

HUD's regulations implementing the FH Act are found at 24 CFR Part 100.

Because both the FH Act and the ECOA apply to mortgage lending, lenders may not discriminate in mortgage lending based on any of the prohibited factors in either list.

Liability under these two statutes for discrimination on a prohibited basis is civil, not criminal. However, there is criminal liability under the FH Act for various forms of interference with efforts to enforce the FH Act, such as altering or withholding evidence or forcefully intimidating persons seeking to exercise their rights under the FH Act.

What is prohibited. Under the ECOA, it is unlawful for a lender to discriminate on a prohibited basis in any aspect of a credit transaction and, under both the ECOA and the FH Act, it is unlawful for a lender to discriminate on a prohibited basis in a residential real estate related transaction. Under one or both of these laws, a lender may not, because of a prohibited factor:

- Fail to provide information or services or provide different information or services regarding any aspect of the lending process, including credit availability, application procedures, or lending standards;
- Discourage or selectively encourage applicants with respect to inquiries about or applications for credit;
- Refuse to extend credit or use different standards in determining whether to extend credit;
- Vary the terms of credit offered, including the amount, interest rate, duration, or type of loan;
- Use different standards to evaluate collateral;
- Treat a borrower differently in servicing a loan or invoking default remedies; or
- Use different standards for pooling or packaging a loan in the secondary market.

A lender may not express, orally or in writing, a preference based on prohibited factors or indicate that it will treat applicants differently on a prohibited basis.

A lender may not discriminate on a prohibited basis because of the characteristics of:

- A person associated with a credit applicant (for example, a co-applicant, spouse, business partner, or live-in aide); or
- The present or prospective occupants of the area where property to be financed is located.

Finally, the FH Act requires lenders to make reasonable accommodations for a person with disabilities when such accommodations are necessary to afford the person an equal opportunity to apply for credit.

B. Types of Lending Discrimination

The courts have recognized three methods of proof of lending discrimination under the ECOA and the FH Act:

- "Overt evidence of discrimination," when a lender blatantly discriminates on a prohibited basis;
- Evidence of "disparate treatment," when a lender treats applicants differently based on one of the prohibited factors; and
- Evidence of "disparate impact," when a lender applies a practice uniformly to all applicants but the practice has a discriminatory effect on a prohibited basis and is not justified by business necessity.

Overt Evidence of Discrimination. There is overt evidence of discrimination when a lender openly discriminates on a prohibited basis.

Example: A lender offered a credit card with a limit of up to $750 for applicants aged 21–30 and $1500 for applicants over 30. This policy violated the ECOA's prohibition on discrimination based on age.

There is overt evidence of discrimination even when a lender expresses—but does not act on—a discriminatory preference:

Example: A lending officer told a customer, "We do not like to make home mortgages to Native Americans, but the law says we cannot discriminate and we have to comply with the law." This statement violated the FH Act's prohibition on statements expressing a discriminatory preference.

Evidence of Disparate Treatment. Disparate treatment occurs when a lender treats a credit applicant differently based on one of the prohibited bases. Disparate treatment ranges from overt discrimination to more subtle disparities in treatment. It does not require any showing that the treatment was motivated by prejudice or a conscious intention to discriminate against a person beyond the difference in treatment itself. It is considered by courts to be intentional discrimination because no credible, nondiscriminatory reason explains the difference in treatment on a prohibited basis.

Example: Two minority loan applicants were told that it would take several hours and require the payment of an application fee to determine whether they would qualify for a home mortgage loan. In contrast, a loan officer took financial information immediately from nonminority applicants and determined whether they qualified in minutes, without a fee being paid. The lender's differential treatment violated both the ECOA and the FH Act.

Redlining refers to the illegal practice of refusing to make residential loans or imposing more onerous terms on any loans made because of the predominant race, national origin, etc., of the residents of the neighborhood in which the property is located. Redlining violates both the FH Act and the ECOA.

Disparate treatment may more likely occur in the treatment of applicants who are neither clearly well-qualified nor clearly unqualified. Discrimination may more readily affect applicants in this middle group for two reasons. First, because the applications are all "close cases," there is more room and need for lender discretion. Second, whether or not an applicant qualifies may depend on the level of assistance the lender provides the applicant in preparing an application. The lender may, for example, propose solutions to problems on an application, identify compensating factors, and provide encouragement to the applicant. Lenders are under no obligation to provide such assistance, but to the extent that they do, the assistance must be provided in a nondiscriminatory way.

Example: A nonminority couple applied for an automobile loan. The lender found adverse information in the couple's credit report. The lender discussed the credit report with them and determined that the adverse information, a judgment against the couple, was incorrect since the judgment had been vacated. The nonminority couple was granted their loan. A minority couple applied for a similar loan with the same lender. Upon discovering adverse information in the minority couple's credit report, the lender denied the loan application on the basis of the adverse information without giving the couple an opportunity to discuss the report.

Example: Two minority borrowers inquired with a lender about mortgage loans. They were given applications for fixed-rate loans only and were not offered assistance in completing the loan applications. They completed the applications on their own and ultimately failed to qualify. Two similarly situated nonminority borrowers made an identical inquiry about mortgage loans to the same lender. They were given information about both adjustable-rate and fixed-rate mortgages and were given assistance in preparing applications that the lender could accept.

Both of these are examples of disparate treatment of similarly situated applicants, apparently based on a

prohibited factor, in the amount of assistance and information the lender provided. The lender might also generally exercise its discretion to disfavor some individuals or favor others in a manner that results in a pattern or practice of disparate treatment that cannot be explained on grounds other than a prohibited basis.

If a lender has apparently treated similar applicants differently on the basis of a prohibited factor, it must provide an explanation for the difference in treatment. If the lender is unable to provide a credible and legitimate nondiscriminatory explanation, the agency may infer that the lender discriminated.

If an agency determines that a lender's explanation for treating some applicants differently is a pretext for discrimination, the agency may find that the lender discriminated, notwithstanding the lender's explanation.

Example: A lender rejected a loan application made by a female applicant with flaws in her credit report but accepted applications by male applicants with similar flaws. The lender offered the explanation that the rejected application had been processed by a new loan officer who was unfamiliar with the bank's policy to work with applicants to correct credit report problems. However, an investigation revealed that the same loan officer who processed the rejected application had accepted applications from males with similar credit problems after working with them to provide satisfactory explanations.

When a lender's treatment of two applicants is compared, even when there is an apparently valid explanation for a particular difference in treatment, further investigation may establish disparate treatment on a prohibited basis. For example, seemingly valid explanations for denying loans to minority applicants may have been applied consistently to minority applicants and inconsistently to nonminority applicants; or "offsetting" or "compensatory" factors cited as the reason for approving nonminority applicants may involve information that the lender usually failed to consider for minority applicants but usually considered for nonminority applicants.

A pattern or practice of disparate treatment on a prohibited basis may also be established through a valid statistical analysis of detailed loan file information, provided that the analysis controls for possible legitimate explanations for differences in treatment. Where a lender's underwriting decisions are the subject of a statistical analysis, detailed information must be collected from individual loan files about the applicants' qualifications for credit. Data reported by lenders under the HMDA do not, standing alone, provide sufficient information for such an analysis because they omit important variables, such as credit histories and debt ratios. HMDA data are useful, though, for identifying lenders whose practices may warrant investigation for compliance with fair lending laws. HMDA data may also be relevant, in conjunction with other evidence, to the determination whether a lender has discriminated.

Evidence of Disparate Impact

When a lender applies a policy or practice equally to credit applicants, but the policy or practice has a disproportionate adverse impact on applicants from a group protected against discrimination, the policy or practice is described as having a "disparate impact." Policies and practices that are neutral on their face and that are applied equally may still, on a prohibited basis, disproportionately and adversely affect a person's access to credit.

Although the precise contours of the law on disparate impact as it applies to lending discrimination are under development, it has been clearly established that proof of lending discrimination using a disparate impact analysis encompasses several steps. The single fact that a policy or practice creates a disparity on a prohibited basis is not alone proof of a violation. Where the policy or practice is justified by "business necessity" and there is no less discriminatory alternative, a violation of the FH Act or the ECOA will not exist.

The existence of a disparate impact may be established through review of how a particular practice, policy or standard operates with respect to those who are affected by it. The existence of disparate impact is not established by a mere assertion or general perception that a policy or practice disproportionately excludes or injures people on a prohibited basis. The existence of a disparate impact must be established by facts. Frequently this is done through a quantitative or statistical analysis. Sometimes the operation of the practice is reviewed by analyzing its effect on an applicant pool; sometimes it consists of an analysis of the practice's effect on possible applicants, or on the population in general. Not every member of the group must be adversely affected for the practice to have a disparate impact. Evidence of discriminatory intent is not necessary to establish that a policy or practice adopted or implemented by a lender that has a disparate impact is in violation of the FH Act or ECOA.

Identifying the existence of a disparate impact is only the first step in proving lending discrimination under this method of proof. When an Agency finds that a lender's policy or practice has a disparate impact, the next step is to seek to determine whether the policy or practice is justified by "business necessity." The justification must be manifest and may not be hypothetical or speculative. Factors that may be relevant to the justification could include cost and profitability.

Even if a policy or practice that has a disparate impact on a prohibited basis can be justified by business necessity, it still may be found to be discriminatory if an alternative policy or practice could serve the same purpose with less discriminatory effect.

Example: A lender's policy is not to extend loans for single family residences for less than $60,000.00. This policy has been in effect for ten years. This minimum loan amount policy is shown to disproportionately exclude potential minority applicants from consideration because of their income levels or the value of the houses in the areas in which they live. The lender will be required to justify the "business necessity" for the policy.

Example: In the past, lenders primarily considered net income in making underwriting decisions. In recent years, the trend has been to consider gross income. A lender decided to switch its practices to consider gross income rather than net income. However, in calculating gross income, the lender did not distinguish between taxable and nontaxable income even though nontaxable income is of more value than the equivalent amount of taxable income. The lender's policy may have a disparate impact on individuals with disabilities and the elderly, both of whom are more likely than the general applicant pool to receive substantial nontaxable income. The lender's policy is likely to be proven discriminatory. First, the lender is unlikely to be able to show that the policy is compelled by business necessity. Second, even if the lender could show business necessity, the lender could achieve the same purpose with less discriminatory effect by "grossing up" nontaxable income (i.e., making it equivalent to gross taxable income by using formulas related to the applicant's tax bracket).

Lenders will not have to justify every requirement and practice every time that they face a compliance examination. The Agencies recognize the relevance to credit decisions of factors related to the adequacy of the borrower's income to carry the loan, the likely continuation of that income, the adequacy of the collateral to secure the loan, the borrower's past performance in paying obligations, the availability of funds to close, and the existence of adequate reserves. While lenders should

think critically about whether widespread, familiar requirements and practices have an unjustifiable disparate impact, they should look especially carefully at requirements that are more stringent than customary. Lenders should also stay informed of developments in underwriting and portfolio performance evaluation so that they are well positioned to consider all options by which their business objectives can be achieved.

C. Answers to Questions Often Asked by Financial Institutions and the Public

Lending institutions and others often ask the Agencies questions about various aspects of lending discrimination. The Agencies have compiled this list of common questions, with answers, in order to provide further guidance.

Q1: Are disparities in application, approval, or denial rates revealed by HMDA data sufficient to establish lending discrimination?

A: HMDA data alone do not prove lending discrimination. The data do not contain enough information on major credit-related factors, such as employment and credit histories, to prove discrimination. Despite these limitations, the data can provide "red flags" that there may be problems at particular institutions. Therefore, regulatory and enforcement agencies may use HMDA data, along with other factors, to identify institutions whose lending practices warrant more scrutiny. Furthermore, HMDA data can be relevant, in conjunction with other data and information, to the determination whether a lender has discriminated.

Q2: Does a lending institution that submits inaccurate HMDA data violate lending discrimination laws?

A: An inaccurate HMDA data submission constitutes a violation of the HMDA, the Federal Reserve Board's Regulation C, and other applicable laws, and may subject the lending institution to an enforcement action, which could include civil money penalties, and, if the lender is a HUD-approved mortgagee, the sanctions of the HUD Mortgagee Review Board. An inaccurate HMDA data submission, however, is not in itself a violation of the ECOA or the FH Act. However, a person who intentionally submits incorrect or incomplete HMDA data in order to cover up a violation of the FH Act may be subject, under the FH Act and federal criminal statutes, to a fine or prison term or both. In addition, a failure to ensure accurate HMDA data may be considered as a relevant fact during a FH Act investigation or an examination of the institution's lending activities.

Q3: Does a second review program only for loan applicants who are members of a protected class violate laws prohibiting discrimination in lending?

A: Such programs are permissible if they do no more than ensure that lending standards are applied fairly and uniformly to all applicants. For example, it is permissible to review the proposed denial of applicants who are members of a protected class by comparing their applications to the approved applications of similarly qualified individuals who are not members of a protected class to determine if the applications were evaluated consistently. It is impermissible, however, to review the applications of members of a protected class in order to apply standards to those applications different from the standards used to evaluate other applications for the same credit program or to apply the same standards in a different manner, unless such actions are otherwise permitted by law, as described in Question 4.

Other types of second review programs are also permissible. For example, lenders could review the proposed denial of all applicants within a certain income range. Lenders also could review a sampling of all applications proposed for denial, or even review all such applications.

Q4: May a lender apply different lending standards to applicants who are members of a protected class in order to increase lending to that sector of its community?

A: Generally, a lender that applies different lending standards or offers different levels of assistance on a prohibited basis, regardless of its motivation, would be violating both the FH Act and the ECOA. There are exceptions to the general rule; thus, applying different lending standards or offering different levels of assistance to applicants who are members of a protected class is permissible in some circumstances. For example, the FH Act requires lenders to provide reasonable accommodation to people with disabilities. In addition, providing different treatment to applicants to address past discrimination would be permissible if done in response to a court order or otherwise in accord with applicable legal precedent. However, the law in this area is complex and developing. Before implementing programs of this sort, a lender should seek legal advice.

Of course, affirmative advertising and marketing efforts that do not involve application of different lending standards are permissible under both the ECOA and the FH Act. For example, special outreach to a minority community would be permissible.

Q5: Should a lender engage in self-testing?

A: Principles of sound lending dictate that adequate policies and procedures be in place to ensure safe and sound lending practices and compliance with applicable laws and regulations, and that a lender adopt appropriate audit and control systems to determine whether the institution's policies and procedures are functioning adequately. This is as true in the area of fair lending as in other operations. Lenders should employ reliable measures for auditing fair lending compliance. A well-designed and implemented program of self-testing could be a valuable part of this process. Lenders should be aware, however, that data documenting lending discrimination discovered in a self-test generally will not be shielded from disclosure.

Corrective actions should always be taken by any lender that discovers discrimination. Self-testing and corrective actions do not expunge or extinguish legal liability for the violations of law, insulate a lender from private suits, or eliminate the primary regulatory agency's obligation to make the referrals required by law. However, they will be considered as a substantial mitigating factor by the primary regulatory agencies when contemplating possible enforcement actions. In addition, HUD and DOJ will consider as a substantial mitigating factor an institution's self-identification and self-correction when determining whether they will seek additional penalties or other relief under the FH Act and the ECOA. The Agencies strongly encourage self-testing and will consider further steps that might be taken to provide greater incentives for institutions to undertake self-assessment and self-correction.

Q6: What should a lender do if self-testing evidences lending discrimination?

A: If a lender discovers discriminatory practices, it should make all reasonable efforts to determine the full extent of the discrimination and its cause, e.g., determine whether the practices were grounded in defective policies, poor implementation or control of those policies, or isolated to a particular area of the lender's operations. The lender should take all appropriate corrective actions to address the discrimination, including, but not limited to:

- Identifying customers whose applications may have been inappropriately processed, offering to extend credit if they were improperly

denied; compensating them for any damages, both out-of-pocket and compensatory; and notifying them of their legal rights;

• Correcting any institutional policies or procedures that may have contributed to the discrimination;

• Identifying, and then training and/or disciplining, the employees involved;

• Considering the need for community outreach programs and/or changes in marketing strategy or loan products to better serve minority segments of the lender's market; and

• Improving audit and oversight systems in order to ensure there is no recurrence of the discrimination.

An institution is not required to report to the Agencies a lending discrimination problem it has discovered. However, a lender that reports its discovery can ensure that the corrective actions it develops are appropriate and complete and thereby minimize the damages to which it will be subject.

Q7: Will a lender be held responsible for discriminatory lending engaged in by a single loan officer where the lending institution has good policies and procedures in place, is otherwise in full compliance with all applicable laws and regulations and neither knows nor reasonably could have known that the officer was engaged in illegal discriminatory conduct?

A: Fair lending violations can occur even in the most well-run lending institutions that have good policies in place to ensure compliance with fair lending laws and regulations. Of course, the chances that such violations will occur can be greatly reduced by backing up those policies with proper employee training and supervision and subjecting the lending process to proven systems of oversight and review. Self-testing can further reduce the likelihood that violations may occur. Notwithstanding these efforts, a single loan officer might still improperly apply policies or, worse yet, deliberately circumvent them and manage to conceal or disguise the true nature of his or her practices for a time. It may be particularly difficult to discover this type of behavior when it occurs in the pre-application process.

In any case where discriminatory lending by a lending institution is identified, the lender will be expected to identify and fairly compensate victims of discriminatory conduct just as it would be expected to compensate a customer if an employee's conduct resulted in physical injury to the customer. In addition, such a violation might constitute a "pattern or practice" that must be referred to DOJ or a violation that must be referred to HUD.

As in other cases of discriminatory behavior, where a lender takes self-initiated corrective actions, such actions will be considered as a substantial mitigating factor by the Agencies in determining the nature of any enforcement action and what penalties or other relief would be appropriate.

Q8: If a federal financial institutions regulatory agency has "reason to believe" that a lender has engaged in a pattern or practice of discrimination in violation of the ECOA, the ECOA requires the agency to refer the matter to DOJ. What constitutes a "reason to believe"?

A: A federal financial institutions regulatory agency has reason to believe that an ECOA violation has occurred when a reasonable person would conclude from an examination of all credible information available that discrimination has occurred. This determination requires weighing the available evidence and applicable law and determining whether an apparent violation has occurred. Information supporting a reason to believe finding may include loan files and other documents, credible observations by persons with direct knowledge, statistical analysis, and the financial institution's response to the preliminary examination findings.

Reason to believe is more than an unfounded suspicion. While the evidence of discrimination need not be definitive and need not include evidence of overt discrimination, it should be developed to the point that a reasonable person would conclude that a violation exists.

Q9: If a federal financial institutions regulatory agency has reason to believe that a lender has engaged in a "pattern or practice" of discrimination in violation of the ECOA, the agency will refer the matter to DOJ. What constitutes a "pattern or practice" of lending discrimination?

A: Determinations by federal financial institutions regulatory agencies regarding a pattern or practice of lending discrimination must be based on an analysis of the facts in a given case. Isolated, unrelated or accidental occurrences will not constitute a pattern or practice. However, repeated, intentional, regular, usual, deliberate, or institutionalized practices will almost always constitute a pattern or practice. The totality of the circumstances must be considered when assessing whether a pattern or practice is present. Considerations include, but are not limited to:

• Whether the conduct appears to be grounded in a written or unwritten policy or established practice that is discriminatory in purpose or effect;

• Whether there is evidence of similar conduct by a financial institution toward more than one applicant. Note, however, that this is not a mathematical process, e.g., "more than one" does not necessarily constitute a pattern or practice;

• Whether the conduct has some common source or cause within the financial institution's control;

• The relationship of the instances of conduct to one another (e.g., whether they all occurred in the same area of the financial institution's operations); and

• The relationship of the number of instances of conduct to the financial institution's total lending activity. Note, however, that, depending on the circumstances, violations that involve only a small percentage of an institution's total lending activity could constitute a pattern or practice.

Depending on the egregiousness of the facts and circumstances involved, singly or in combination, these factors could provide evidence of a pattern or practice.

Q10: How does the employment of few minorities and individuals from other protected classes in lending positions—e.g., Account Executive, Underwriter, Loan Counselor, Loan Processor, Staff Appraiser, Assistant Branch Manager and Branch Manager—affect compliance with lending discrimination laws?

A: The employment of few minorities and others in protected classes, in itself, is not a violation of the FH Act or the ECOA. However, employment of few members of protected classes in lending positions can contribute to a climate in which lending discrimination could occur by affecting the delivery of services.

Therefore, lenders might consider the following steps, as appropriate to their institutions:

• Advertising lending job openings in local minority-oriented publications;

• Notifying predominantly minority organizations of such openings;

• Seeking employment referrals from current minority employees, minority real estate boards and local historically minority colleges and other institutions that serve minority groups in the community; and

• Seeking qualified independent fee appraisers from local minority appraisal organizations.

Similar outreach steps could be considered to recruit women, persons with disabilities, and other persons protected by the FH Act and the ECOA.

Q11: What is the role of the guidelines of secondary market purchasers and

private and governmental loan insurers in determining whether primary lenders practice lending discrimination?

A: Many lenders make mortgage loans only when they can be sold on the secondary market, or they may place some loans in their own portfolios and sell others on the secondary market. The principal secondary market purchasers, Federal National Mortgage Association ("Fannie Mae") and Federal Home Loan Mortgage Corporation ("Freddie Mac"), publish underwriting guidelines to inform primary lenders of the conditions under which they will buy loans. For example, ability to repay the loan is measured by suggested ratios of monthly housing expense to income (28%) and total obligations to income (36%). However, these guidelines allow considerable discretion on the part of the primary lender. In addition, the secondary market guidelines have in some cases been made more flexible, for example, with respect to factors such as stability of income (rather than stability of employment) and use of nontraditional ways of establishing good credit and ability to pay (e.g., use of past rent and utility payment records). Lenders should ensure that their loan processors and underwriters are aware of the provisions of the secondary market guidelines that provide various alternative and flexible means by which applicants may demonstrate their ability and willingness to repay their loans. Fannie Mae and Freddie Mac not infrequently purchase mortgages exceeding the suggested ratios, and their guidelines contain detailed discussions of the compensating factors that can justify higher ratios (and which must be documented by the primary lender).

A lender who rejects an application from an applicant who is a member of a protected class and who has ratios above those of the guidelines and approves an application from another applicant with similar ratios should be prepared to show that the reason for the rejection was based on factors that are applied consistently without regard to any of the prohibited factors.

These same principles apply equally to the guidelines of private and governmental loan insurers.

Q12: What criteria will be employed in taking enforcement actions or seeking remedial measures when lending discrimination is discovered?

A: Enforcement sanctions and remedial measures for lending discrimination violations vary depending on whether such sanctions are sought by the appropriate federal financial institutions regulatory agencies, DOJ, HUD or other federal agencies charged with enforcing either the ECOA or the FH Act. The following discussion sets out the criteria typically employed by the federal banking agencies (i.e., OCC, OTS, the Board and FDIC), NCUA, DOJ, HUD, OFHEO, FHFB and FTC in determining the nature and severity of sanctions that may be used to address discriminatory lending practices. As discussed in Questions 8 and 9, above, in certain situations, the primary regulatory agencies will also refer enforcement matters to HUD or DOJ.

The federal banking agencies:

The federal banking agencies are authorized to use the full range of their enforcement authority under 12 U.S.C. 1818 to address discriminatory lending practices. This includes the authority to seek:

- Enforcement actions that may require both prospective and retrospective relief; and
- Civil money penalties ("CMPs") in varying amounts against the financial institution or any institution-affiliated party ("IAP") within the meaning of 12 U.S.C. 1813(u), depending, among other things, on the nature of the violation and the degree of culpability.

In addition to the above actions, the federal banking agencies may also take removal and prohibition actions against any IAP where the statutory requirements for such actions are met.

The federal banking agencies will make determinations as to the appropriateness of any potential enforcement action after giving full consideration to a variety of factors. In making these determinations, the banking agencies will take into account:

- The number and duration of violations identified;
- The nature of the evidence of discrimination (i.e., overt discrimination, disparate treatment or disparate impact);
- Whether the discrimination was limited to a particular office or unit of the financial institution or was more pervasive in nature;
- The presence and effectiveness of any anti-discrimination policies;
- Any history of discriminatory conduct; and
- Any corrective measures implemented or proposed by the financial institution.

The severity of the federal banking agencies' enforcement response will depend on the egregiousness of the financial institution's conduct. Voluntary identification and correction of violations disclosed through a self-testing program will be a substantial mitigating factor in considering whether to initiate an enforcement action.

In addition, the federal banking agencies may consider whether an institution has provided victims of discrimination with all the relief available to them under applicable civil rights laws.

The federal banking agencies may seek both prospective and retrospective relief for fair lending violations.

Prospective relief may include requiring the financial institution to:

- Adopt corrective policies and procedures and correct any financial institution policies or procedures that may have contributed to the discrimination;
- Train financial institution employees involved;
- Establish community outreach programs and change marketing strategy or loan products to better serve all sectors of the financial institution's service area;
- Improve internal audit controls and oversight systems in order to ensure there is no recurrence of discrimination; or
- Monitor compliance and provide periodic reports to the primary federal regulator.

Retrospective relief may include:

- Identifying customers who may have been subject to discrimination and offering to extend credit if the customers were improperly denied;
- Requiring the financial institution to make payments to injured parties:
- *Restitution*: This may include any out-of-pocket expenses incurred as a result of the violation to make the victim of discrimination whole, such as: fees or expenses in connection with the application; the difference between any greater fees or expenses of another loan granted elsewhere after denial by the discriminating lender; and, when loans were granted on disparate terms, appropriate modification of those terms and refunds of any greater amounts paid.
- *Other Affirmative Action As Appropriate to Correct Conditions Resulting From Discrimination:* The federal banking agencies also have the authority to require a financial institution to take affirmative action to correct or remedy any conditions resulting from any violation or practice. The banking agencies will determine whether such affirmative action is appropriate in a given case and, if such action is appropriate, the type of remedy to order.
- Requiring the financial institution to pay CMPs:

The banking agencies have the authority to assess CMPs against financial institutions or individuals for violating fair lending laws or

regulations. Each agency has the authority to assess CMPs of up to $5,000 per day for any violation of law, rule or regulation. Penalties of up to $25,000 per day are also permitted, but only if the violations represent a pattern of misconduct, cause more than minimal loss to the financial institution, or result in gain or benefit to the party involved. CMPs are paid to the U.S. Treasury and therefore do not compensate victims of discrimination.

National Credit Union Administration

For federal credit unions, NCUA will employ criteria comparable to those of the federal banking agencies, pursuant to its authority under 12 U.S.C. 1786.

The Department of Justice

The Department of Justice is authorized to use the full range of its enforcement authority under the FH Act and the ECOA. DOJ has authority to commence pattern or practice investigations of possible lending discrimination on its own initiative or through referrals from the federal financial institutions regulatory agencies, and to file lawsuits in federal court where there is reasonable cause to believe that such violations have occurred. DOJ is also authorized under the FH Act to bring suit based on individual complaints filed with HUD where one of the parties to the complaint elects to have the case heard in federal court.

The relief sought by DOJ in lending discrimination lawsuits may include:

- An injunction which may require both prospective and retrospective relief; and,
- In enforcement actions under the FH Act, CMPs not to exceed $50,000 per defendant for a first violation and $100,000 for any subsequent violation.

Prospective injunctive relief may include:

- A permanent injunction to insure against a recurrence of the unlawful practices;
- Affirmative measures to correct past discriminatory policies, procedures, or practices, so long as consistent with safety and soundness, such as:
- Expansion of the lender's service areas to include previously excluded minority neighborhoods;
- Opening branches or other credit facilities in under-served minority neighborhoods;
- Targeted sales calls on real estate agents and builders active in minority neighborhoods;
- Advertising through minority-oriented media;
- Self-testing;
- Employee training;
- Changes to commission structures which tend to discourage lending in minority and low-income neighborhoods; and
- Changes in loan processing and underwriting procedures (including second reviews of denied applications) to ensure equal treatment without regard to prohibited factors; and
- Record keeping and reporting requirements to monitor compliance with remedial obligations.

Retrospective injunctive relief may include relief for victims of past discrimination; actual and punitive damages, and offers or adjustments of credit or other forms of loan commitments.

The Department of Housing and Urban Development

The Department of Housing and Urban Development is fully authorized to investigate complaints alleging discrimination in lending in violation of the FH Act and has the authority to initiate complaints and investigations even when an individual complaint has not been received. HUD issues determinations on whether or not reasonable cause exists to believe that the FH Act has been violated. HUD also may authorize actions for temporary and preliminary injunctions to be brought by DOJ and has authority to issue enforceable subpoenas for information related to investigations.

Following issuance of a determination of reasonable cause under the FH Act, HUD enforces the FH Act administratively unless one of the parties elects to have the case heard in federal court in a case brought by DOJ.

Relief under the FH Act that may be awarded by an administrative law judge ("ALJ") after a hearing, or by the Secretary on review of a decision by an ALJ, includes:

- Injunctive or other appropriate relief, including a variety of actions designed to correct discriminatory practices, such as changes in loan processes or procedures, modifications of loan service areas or branching actions, approval of previously denied loans to aggrieved persons, additional record-keeping and reporting on future activities or other affirmative relief;
- Actual damages suffered by persons who are aggrieved by any violation of the FH Act, including damages for mental distress and out-of-pocket losses attributable to a violation; and
- Civil penalties of up to $10,000 for each initial violation and up to $25,000 and $50,000 for successive violations within specific time frames.

HUD also is authorized to direct Fannie Mae and Freddie Mac to undertake various remedial actions, including suspension, probation, reprimand, or settlement, against lenders found to have engaged in discriminatory lending practices in violation of the FH Act or the ECOA.

The Office of Federal Housing Enterprise Oversight

The Office of Federal Housing Enterprise Oversight is authorized to use its enforcement authority under 12 U.S.C. 4631 and 4636, including cease and desist orders and CMPs for violations by Fannie Mae and Freddie Mac of the fair housing regulations promulgated by the Secretary of HUD pursuant to 12 U.S.C. § 4545.

The Federal Housing Finance Board

While the Federal Housing Finance Board does not have enforcement authority under the ECOA or the FH Act, in reviewing the members of the Federal Home Loan Bank System for community support, it may restrict access to long-term System advances to any member that, within two years prior to the due date of submission of a Community Support Statement, had a final administrative or judicial ruling against it based on violations of those statutes (or any similar state or local law prohibiting discrimination in lending). System members in this situation are asked to submit to the Finance Board an explanation of steps taken to remedy the violation or prevent a recurrence. See 12 U.S.C. 1430(g); 12 CFR 936.3 (b)(5).

The Federal Trade Commission

The Federal Trade Commission enforces the requirements of the ECOA and Regulation B for all lenders subject to the ECOA, except where enforcement is specifically committed to another agency. The FTC may exercise all of its functions and powers under the Federal Trade Commission Act ("FTC Act") to enforce the ECOA, and a violation of any requirement under the ECOA is deemed to be a violation of a requirement under the FTC Act. The FTC has the power to enforce Regulation B in the same manner as if a violation of Regulation B were a violation of an FTC trade regulation rule.

This means that the FTC has the power to investigate lenders suspected of lending discrimination and to use compulsory process in doing so. The Commission, through DOJ or on its own behalf where the Justice Department declines to act, may file suit in federal court against suspected violators and seek relief including:

- Injunctions against the violative practice;

• Civil penalties of up to $10,000 for each violation; and

• Redress to affected consumers.

In addition, the Commission routinely imposes recordkeeping and reporting requirements to monitor compliance.

Q13: Will a financial institution be subjected to multiple actions by DOJ or HUD and its primary regulator if discriminatory practices are discovered?

A: In all cases where referrals to other agencies are made, the appropriate federal financial institutions regulatory agency will engage in ongoing consultations with DOJ or HUD regarding coordination of each agency's actions. The Agencies will coordinate their enforcement actions and make every effort to eliminate unnecessarily duplicative actions. Where both a federal financial institutions regulatory agency and either DOJ or HUD are contemplating taking actions under their own respective authorities, the Agencies will seek to coordinate their actions to ensure that each agency's action is consistent and complementary. The financial institutions regulatory agencies also will discuss referrals on a case-by-case basis with DOJ or HUD to determine whether multiple actions are necessary and appropriate.

Dated: April 6, 1994.

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Acting Director, Office of Thrift Supervision.

Alan Greenspan,

Chairman, Board of Governors of the Federal Reserve System.

Andrew C. Hove, Jr.,

Acting Chairman, Federal Deposit Insurance Corporation.

Nicolas P. Retsinas,

HUD—Secretary, Designee to the Board, Federal Housing Finance Board.

Donald S. Clark,

Secretary, Federal Trade Commission.

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